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ARGUMENT

Scott (Came)

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Ontario

ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND  
RELATED MATTERS.

Hearing held  
21 floor  
180 Dundas Street West  
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange	Commissioner
P.S.A. Lamok, Q.C.	Counsel
E.A. Cronk	Associate Counsel
Thomas Millar	Administrator

Transcript of evidence  
for

June 14, 1984

VOLUME 155

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ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN  
AND RELATED MATTERS

Hearing held on the 21st Floor,  
180 Dundas Street West, Toronto,  
Ontario, on Thursday, the 14th  
day of June, 1984.

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner  
THOMAS MILLAR - Administrator  
MURRAY R. ELLIOT - Administrator

APPEARANCES:

P.S.A. LAMEK, Q.C.	)	Commission Counsel
E. CRONK	)	
D. HUNT	)	Counsel for the Attorney
L. CECCHETTO	)	General and Solicitor
		General of Ontario (Crown
		Attorneys and Coroner's
		Office
I.G. SCOTT, Q.C.	)	Counsel for The Hospital
M. THOMSON	)	for Sick Children
R. BATTY		
D. YOUNG	)	Counsel for The
		Metropolitan Toronto
		Police
W.N. ORTVED	)	Counsel for numerous
K. CHOWN	)	Doctors at The Hospital
		for Sick Children





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APPEARANCES: (CONT'D)

3

D. BROWN ) Counsel for Susan Nelles-  
Nurse

4

5

G.R. STRATHY ) Counsel for Phyllis Trayner -  
P. RAE ) Nurse

6

J.A. OLAH ) Counsel for Janet Brownless -  
R.N.A.

7

S. LABOW ) Counsel for Mr. & Mrs.  
Gosselin, Mr. & Mrs. Gionas,  
Mr. & Mrs. Inwood, Mr. & Mrs.  
Turner, Mr. & Mrs. Lutes,  
and Mr. & Mrs. Murphy  
(parents of deceased children)

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10

F.J. SHANAHAN ) Counsel for Mr. & Mrs. Dominic  
Lombardo (parents of deceased  
child Stephanie Lombardo) and  
Heather Dawson (mother of  
deceased child Amber Dawson)

11

12

13

W.W. TOBIAS ) Counsel for Mr. & Mrs. Hines  
(parents of deceased child  
Jordan Hines)

14

15

J. SHINEHOFT ) Counsel for Lorie Pacsai and  
Kevin Garnet (parents of  
deceased child Kevin Pacsai)

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VOLUME 155

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May 17, 1984                      E R R A T A                      VOLUME 147

Page No. 3704, line 15 - "caused their death" should  
read "came to their death"

Page No. 3733, lines 2,3 and 6 "an argument" should read  
"in argument"

June 5, 1984    VOLUME 149


Page No. 294, lines 13,16 and 26 "HPLA" should read  
"HPLC"

June 6, 1984    VOLUME 150

Page 500, line 6 - "11 pediatric ampules" should read  
"10 pediatric ampules"

Page 535, line 13 - delete "save - I'm sorry"

Page 544, line 15 - "Dr. Coutts" should read "Dr. Cutz"



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I N D E X

ARGUMENT BY MR. SCOTT (CONTINUED)	1093
ARGUMENT BY MR. ORTVED	1157





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--On commencing at 10:00 a.m.

THE COMMISSIONER: Yes, Mr. Scott.

ARGUMENT BY MR. SCOTT (CONTINUED)

MR. SCOTT: Mr. Scott, in my submissions to you yesterday, particularly at the end of the day I was trying to show that although much has been learned about the drug digoxin and its pharmacokinetics, much is still to be learned. We are, as I submit, still learning about, for example, the nature of the beta phase, how long the body takes to eliminate digoxin and how it is stored in the various tissues of the body.

It is fair to say in my submission that in March of 1981 when we knew very little about these matters, to Mr. Cimbura's credit and that of the Centre of Forensic Sciences, tests had to be developed for tissue analysis and the scientific community has, to use Mr. Lamek's phrase, continued on a steep learning curve since that date in 1981 in its efforts to assess the reliability of the testing mechanisms applied.

The November conference and the continuing research of which you have had some evidence, indicates that the learning curve is still being pursued, much remains to know.





1  
2 If I may turn, as an example, to one  
3 of the children under investigation to make this  
4 point, the Baby Estrella. In March, 1981 it was  
5 believed that Janice Estrella had received a massive  
6 overdose of digoxin which had resulted in her death.  
7 This opinion was based on a 72 reading from a sample  
8 of gutter blood, which although it was known at the  
9 time to be contaminated, or suspected to be contaminated,  
10 was believed nonetheless to be significant in light  
11 of subsequent digoxin readings. That was the state  
12 in 1981.

13 Almost one year later at the pre-  
14 liminary hearing the view was expressed that the  
15 contamination would probably reduce the reading  
16 rather than elevate it. In a sense the scientific  
17 view had come full circle in slightly less than a  
18 year. Due to this concern, Dr. Phillips of the  
19 Hospital and Mr. Cimbura undertook the gutter blood  
20 study which has been outlined in detail by Ms. Cronk.

21 That study was designed as a control  
22 test for the Estrella sample and what it produced  
23 by way of results was notable. When post mortem  
24 blood values were compared with samples of gutter  
25 blood the multiplier effect with which we are now  
quite familiar was found, but in addition one gutter





1  
2 blood reading of 169 nanograms was exhibited in one  
3 patient. This is significant in our submission for  
4 two reasons; first, it shows that a gutter blood  
5 sample may show gross elevation if contaminated by  
6 fecal or urine matters.

7 Second, in the opinion of experts  
8 who appeared before you, it seriously undermined any  
9 reliability which could be placed in the gutter blood  
10 samples secured from Janice Estrella.

11 THE COMMISSIONER: Not all of them.

12 MR. SCOTT: Well, not Dr. Mirkin but  
13 almost everybody else, I think everybody else.

14 THE COMMISSIONER: What Dr. Mirkin says,  
15 it depends on how you are looking at it, you can look  
16 it and say one out of 25 was one out of line; the  
17 other way of looking at it is 24 out of 25 were very  
18 consistent.

19 MR. SCOTT: How on earth, sir, are you  
20 going to resolve that scientific confrontation except  
21 by examining the weight of medical authority, the  
22 weight of scientific authority.

23 THE COMMISSIONER: I can read the chart  
24 just as well as they can.

25 MR. SCOTT: Yes, but in my respectful  
submission only a scientist can resolve that and the





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scientists are not agreed.

THE COMMISSIONER: I don't need the scientists for that, I don't need the scientists for that. Either Dr. Mirkin is logical or he isn't, and if he makes sense I can assess it. I can read figures as well as he, Dr. Kauffman, or Dr. Hastreiter and anybody else. If he reaches this conclusion, and it may not be the correct conclusion, but it is one conclusion that you can draw from that gutter blood study.

MR. SCOTT: Everybody can read the figures, no question about that, even as I am showing I can read the figures. What can't be done except on the basis of weighing scientific evidence is to assess the impact of the figures. What I say is that Dr. Mirkin is inconsistent in this case with the weight of scientific authority, and it would be, respectfully, imprudent to rely at this stage of scientific knowledge on the view of a scientist whose views are not shared by any of the other experts.

THE COMMISSIONER: Yes, but they are basing it upon the gutter blood study, and I can look at the gutter blood study and so can you and reach our own conclusions.

MR. SCOTT: Yes, but it is how you





1  
2 assess the impact of that study.

3 THE COMMISSIONER: I am not sure I  
4 know what that means. I look at the gutter blood  
5 study and I either reach the conclusion that it is  
6 very, very dangerous to rely upon gutter blood because  
7 one out of 25 was wildly wrong.

8 MR. SCOTT: Yes.

9 THE COMMISSIONER: Or I reach the  
10 conclusion it would be very easy to rely on it because  
11 24 out of 25 were very close.

12 MR. SCOTT: Well I will leave the  
13 matter, except to emphasize that it is not entirely  
14 a non-scientific logical exercise, it is a scientific  
15 exercise. It is my respectful submission that you  
16 will not want to reach a conclusion about that matter,  
17 for example, in the case of Baby Estrella that is  
18 inconsistent with the weight of scientific authority.

19 Dr. Kauffman, for example, and I have  
20 set this out, a summary of it in my white binder at  
21 Tab 23, confirms a category of uncertainty in  
22 interpreting any concentrations arising from the gutter  
23 blood sample, and because of this, as you know, he  
24 revised his categorization of the Baby Estrella  
25 from a 4 to a value of 2. As he put it, these are  
his words:





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"The loss of confidence in this  
reading really left very little else  
to deal with."

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Now that is the scientific conclusion,  
that this gutter blood study reduces scientific  
confidence in the reading. In my respectful submission  
when Dr. Kauffman says that one has to be very careful  
in assessing an opinion to the contrary.

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THE COMMISSIONER: When he bases it  
entirely upon - this is what I have been saying the  
last few days, there is no doubt that the scientists  
know a great deal more about every scientific matter  
than I do, but where they start giving me reasons and  
the reasons don't make any sense to me I don't have  
to accept their views. This is the only thing that  
Kauffman bases it on, was the gutter blood study.  
If I don't think he had any right to draw that  
conclusion from the gutter blood study why can't I  
draw another conclusion?

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MR. SCOTT: You are perfectly entitled,  
we have been around this mulberry bush before, sir,  
you are perfectly entitled to draw any conclusion  
you want. What I am saying is it would be imprudent,  
respectfully, if the decisions of the Commission are to have  
validity in the scientific community, to draw conclusions





1  
2 that are inconsistent with the weight of scientific  
3 authority.

4 THE COMMISSIONER: Well I am not here  
5 to satisfy scientists, I am here to tell what happened  
6 to these children.

MR. SCOTT: Yes.

7 THE COMMISSIONER: And if they tell  
8 me the only basis, as you say we have been through  
9 this before, if they tell me because of this gutter  
10 blood study, I can look at the gutter blood study and  
11 I can read it just as well as they can.

12 MR. SCOTT: Mr. Commissioner, if  
13 Pope Innocent the Third had a point in the Commission  
14 to determine whether the world was flat or round  
15 in the Seventeenth Century, experts would have come  
16 no doubt from far and near who would have given their  
17 evidence and you would have to assess their evidence.  
18 But if it were left to a judge in the Seventeenth  
19 Century it would have been concluded without any  
20 doubt that the world was flat. Because you have to  
21 assess the science, its stage of development and what  
22 we can actually know.

23 What I say to you is that Dr. Kauffman  
24 is of that view, Dr. Hastreiter who shares little with  
25 Dr. Kauffman on matters of conclusion is of the same

Not if  
Christopher  
Columbus  
gave us and  
persuaded the  
judge that  
his view was  
to be preferred  
over that of  
all the  
others.





1  
2 view at Volume 77, page 6974, he confirmed that  
3 because of the study the significance of the sample  
4 was reduced considerably and he changed his evaluation.

5 Mr. Cimbura is of the same view at  
6 Volume 52, page 1697. Dr. Spielberg is of the same  
7 view at page 2352 and I don't have the volume. Dr.  
8 Phillips is of the same view at Volume 58, page  
2994 and only Dr. Mirkin takes a different view.

9 Now in my respectful submission while  
10 you are entitled to accept or reject any expert  
11 opinion you want, it cannot be stopped, and my  
12 submission to you is that you will want in the end  
13 to be very careful before you reject the evidence,  
14 the conclusion, the scientific conclusion of Dr.  
15 Kauffman, Dr. Hastreiter, Mr. Cimbura, Dr. Phillips  
16 and Dr. Spielberg, whose opinions you are going to  
17 accept on other matters from time to time, when there  
is a lone outlier who takes the contrary view.

18 Now I put it no higher than that, it  
19 is a matter that you will have to consider but it  
20 seems to me it would be taking extraordinary risks  
21 in a scientific area to draw that conclusion in the  
face of that evidence.

22 The significant point it seems to me  
23 to be made about the Estrella sample is that that is a  
24  
25





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sample which on the basis of scientific knowledge in  
1981, founded in part the criminal prosecution, and  
upon which much learned opinion was founded, it was  
subjected to the learning process in the scientific  
community.

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What has been learned in the interval about that sample in my respectful submission seriously challenges the beliefs that were previously held. Scientists are no longer prepared to act on a reading that they were at one stage prepared to act on because the learning curve has produced information about the sampling process that is significant, in their view.

Now the Estrella case thus becomes of concern to you and you must approach it, as I had said, cautiously. Its major significance is that it demonstrates how much is still to be learned about the toxicological data being placed before you. On Estrella, one other point, with regard to the blood sample drawn from the leg vein of Estrella, Commission Counsel has submitted that the evidence of Dr. Taylor, the doctor who actually drew the sample, should be accepted by the Commission. His evidence of course is that in his opinion the sample was not contaminated. It is submitted that the fact that Dr. Taylor actually drew the sample does not qualify him uniquely to comment on the potential contamination of the sample from a pharmacological point of view. In contrast to his evidence, you heard that there could well have been





B-2

1  
2 a potential for contamination either around the  
3 opening of the leg vein into which the syringe  
4 had been inserted or also as a result of edema  
5 fluid diffusing into the leg vein as a consequence  
6 of the technique of manually milking the leg vein  
7 to draw sufficient blood sample. For that you have  
8 the evidence of Dr. Cutz at Volume 44, page 9017.

9 In light of this evidence which  
10 indentifies two plausible sources of contamination  
11 of the leg vein sample I submit that the digoxin  
12 level may also have been falsely elevated.

13 On the same general subject may  
14 I turn, that is, the subject of the utility of the  
15 toxicological data, can I turn to the case of the  
16 Baby Inwood. The sample we have available on that  
17 baby, if reliable, clearly suggests that digoxin  
18 played a role in her death; I emphasize, if reliable.  
19 The sample, reportedly serum, reveals a reading of  
20 491 nanograms, an astronomical figure. However, it  
21 is our submission at this stage we simply know  
22 too little about the storage and reliability of  
23 this sample for you confidently to place any  
24 significant weight on it. Both Dr. MacLeod and  
25 Dr. Spielberg have expressed before you strong  
concerns about the integrity of the sample as a

*There is a  
strong attack  
than this  
on the leg-vein  
sample!*





B-3

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consequence of the manner in which it was stored.

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Dr. MacLeod voiced the concern that heating and

4

cooling could have caused some breakdown of the

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contents of the tube and produced a substance which

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could interfere with the digoxin reading. Again

7

it is fair to say, in my respectful submission,

8

that we are still learning and you will not want

9

to reach an important determination with respect to

10

the case of the Baby Inwood on the basis of a

11

sample which is suspect in the scientific community.

12

You are going to have lots of decisions to make

13

that can be founded on reliable, cogent, scientifically

14

supported evidence. It is not, in my respectful

15

submission, appropriate to make determinations

16

that are not so based.

17

Now, Miss Cronk in her submission

18

made reference to the redistribution principle

19

whereby the tissue bound digoxin releases into serum.

20

This may well be part of the dying process of the

21

tissues themselves but it was also raised by

22

Dr. Spielberg in his discussion of the trauma caused

23

to the Miller child during the resuscitation effort.

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If I understand Dr. MacLeod's evidence which is set

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out beginning at Volume 63, page 4133, the process

works like this. He says that only one half of 1% of the





B-4

1  
2 digoxin remains in the serum while the remaining  
3 99.5% is bound in the tissue. If we accept the  
4 premise that tissue bound digoxin may be released  
5 prior to death as a consequence of gradual deterioration  
6 of tissue or some source of trauma experienced by  
7 the tissue it would only require a relatively small  
8 amount of digoxin to be released from the tissue  
9 into the serum to achieve a proportionately significant  
10 elevation in the serum digoxin level. It is for  
11 this reason that Dr. Spielberg attributes the  
12 elevated level of digoxin in Baby Pacsai to  
13 pathophysiology, which he does in his discussion in  
14 Volume 55, page 2333. In further support of this  
15 concept Dr. Spielberg made reference to three  
16 specific examples which he called Babies A, B, and C  
17 at Volume 56, page 2410. In those examples digoxin  
18 serum levels continued to rise or remain constant  
19 notwithstanding the fact the administration of  
20 digoxin has been held. The logical explanation for  
21 this elevation of serum digoxin is a redistribution  
22 of existing stores of tissue bound digoxin into serum.  
23 That being the case Baby Pacsai could well be explained  
24 by such a process.

25  
26 Dr. MacLeod as well supports the  
27 position by indicating that the concept of pathophysiology





B-5

1  
2 as postulated at the Murphy inquest changed his  
3 thinking about Pacsai and in fact strengthened the  
4 argument for pathophysiology as a cause of death  
5 in Pacsai.

6 Again you have a conflict among  
7 experts related to the death of certain particular  
8 babies and in my respectful submission where that  
9 conflict is legitimate, where it may be put to  
10 rest by future scientific enquiry, it would be  
11 imprudent and unfair to the participants in my  
12 respectful submission to draw a conclusion that that  
13 baby had been killed by an illicit administration of  
14 digoxin. As I say there will be enough determinations  
15 that you can make on firm evidence to avoid the  
16 necessity of exploring terra nova where conclusions  
17 cannot, in my respectful submission, be drawn.

18 Now let me turn for a moment to the  
19 acknowledged difficulty in our submissions to this  
20 point with respect to the toxicological data. You  
21 may well ask, indeed perhaps you have, how can I  
22 reach any decision with respect to these babies, when  
23 even if I have reasonably conclusive evidence in the  
24 form of toxicological data, when you say there are a  
25 multitude of confounding factors. We have from the  
beginning of this Commission believed that it was





B-6

1  
2 and remains important that you have before you all  
3 of the very best evidence possible on the subject  
4 of digoxin to date. Your own Counsel has made  
5 determined efforts in that regard. Having thus  
6 placed before you the most up-to-date and relevant  
7 knowledge, inconclusive as it may be, inconsistent  
8 as it may be, you may well be able to reach a  
9 conclusion with respect to specific babies when you  
10 appropriately weigh the evidence of the toxicological  
11 data. But I emphasize again that it is important  
12 that you recognize the matters learned and to  
13 be learned with respect to the pharmacokinetics of this  
14 drug and that you approach the evidence with a  
15 considerable degree of caution because of the presence  
16 of these scientific confounders.

17 Before I leave the issue of toxicological  
18 data I want to turn briefly to readings on exhumed,  
19 embalmed and fixed tissues because it will be my  
20 submission that it would not be wise or prudent to  
21 propound any significant conclusion in relation to  
22 these babies on readings from those tissues. A  
23 review of the evidence clearly reveals that  
24 Drs. Kauffman and Hastreiter and Mr. Cimbura attach  
25 quantitative credibility to the digoxin levels  
obtained from such samples. At best these readings





B-7

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may indicate the presence or absence of the drug  
in a particular sample. Therefore it is clear  
that where a child has been administered digoxin  
in life, such indicators are really of no assistance  
to you. Dr. Kauffman spoke on exhumed tissue at  
Volume 70, page 5479 and fixed tissue at Volume 70,  
page 5484 and he said both fixed and exhumed tissue  
levels are very problematic.

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RD. jc 1  
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2 Dr. Hastreiter, on exhumed and  
3 fixed tissue samples, at Volume 75, page 6581, said:

4 "I would agree with the assertion  
5 that quantitative measurements cannot  
6 be made appropriately."

7 Mr. Cimbura, on exhumed tissue  
8 readings, Volume 52 at page 1750, says:

9 "Comparison of digoxin values  
10 from exhumed autopsy material with  
11 those of fixed tissue may not be  
12 valid."

13 He repeatedly refers to his results as being  
14 inconclusive with respect to dig. toxicity.

15 There were also clear problems with  
16 fixed tissue readings. Dr. Kauffman at Volume 70,  
17 page 5477, says, and I quote:

18 "I think a quantitative inter-  
19 pretation of digoxin results from  
20 fixed tissue is fraught with problems  
21 and I think it is helpful only to  
22 say that digoxin is there or is not  
23 there."

24 Mr. Cimbura at Volume 53, in response  
25 to your observation that tissue levels are  
confirmatory at best of the blood test replied:





C.2

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"Blood values are, I consider, most significant. Fresh tissues are supportive evidence only. The fixed tissue is mainly inconclusive. Embalmed tissues are mainly inconclusive."

Now it is because of all these reservations that we submit to you that you can safely draw no conclusions whatever from digoxin tissue readings from exhumed, embalmed or fixed tissue, except in the qualitative sense.

This, sir, limits your findings about digoxin involvement in the death of those babies who were not prescribed digoxin and, yet, in whom digoxin was found in exhumed tissues. I am thinking of Lombardo, Belanger and Hines.

Miss Cronk and Mr. Lamek have urged you to consider the readings from exhumed and fixed tissues in comparison to the levels in fresh tissue, acknowledged to be within the fatal toxic range, as a kind of corroborative evidence. Because of the inherent reservations of Drs. Kauffman, Hastreiter and Mr. Cimbura, such comparisons are not, in our submission, scientifically valid. They simply cannot be made and the material cannot be used in the light of the scientific evidence.





C.3

1  
2 Now, it may be said, well, the  
3 Commissioner can use whatever he finds helpful, and  
4 I cannot do anything but make the submission, but  
5 the submission I make to you is to use for any  
6 purpose samples that the scientific community or the  
7 bulk of the scientific community regard as  
8 inconclusive is to build your determinations on  
9 footings of sand.

10 There will be plenty of decisions  
11 to be made where the evidence is consistent, direct,  
12 generally supported and conclusive. It will not be  
13 necessary, in my respectful submission, nor will you  
14 want to make such important findings on evidence  
15 which any significant member of the scientific  
16 community characterizes as conclusive.

17 Now, where, in my respectful  
18 submission did all this leave us? In looking at the  
19 evidence I have given you, and you may want to  
20 accept or reject some or all of them, nine guidelines  
21 about the way in which you should approach the  
22 exercise before you.

23 In the case of each baby it requires  
24 an evaluation of the items of evidence that are  
25 relevant to that baby. Much of that is neutral and  
if it is neutral, as we said yesterday, it proves





C.4

1  
2 nothing. The sudden and unexpected death business.  
3 That is an inherent factor in the population under  
4 investigation. The nature of terminal events,  
5 equally consistent with the diseased state or with  
6 digoxin intoxication. Demonstrations of bradycardia,  
7 arrhythmia, ventricular fibrillation or vomiting, the  
8 way in which babies die - a neutral fact. The fact  
9 that no cause is pinpointed at the Hospital autopsy -  
10 a neutral fact. The high failure of resuscitation  
11 attempts. Unproved, but even if it was so a neutral  
12 fact. The use of a pattern. The pattern must await  
13 the determination you make and cannot be used to  
14 substantiate a determination you propose to make.

14 These are the neutral factors and,  
15 in my respectful submission, if they are neutral,  
16 they cannot be used for any purpose, direct proof  
17 or corroborative.

17 Therefore, it will be important for  
18 you to develop, as I suggested in opening, objective  
19 standards which you can apply in looking at the  
20 individual toxicological data in the children. That  
21 toxicological data, in my submission, must be taken  
22 with the reserve that I noted at the end of yesterday  
23 and today and, particularly, the reserve with respect to  
24 embalmed, exhumed and fixed tissues. Therefore, you  
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C.5

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may use it, for example, in the case of Lombardo, Belanger and Hines, but you can not use it, it is not relevant to assist you to determine whether the administration was deliberate. It is there, it was administered, but you cannot use it to conclude that the administration was deliberate or, indeed, that it caused death.

Now, let me turn to the binder we have put before you and I want to make two comments about it first. This binder, as you will have seen, is a catalogue of all the babes who died in this period, arranged chronologically, and I described the other day the way it is made up.

The first page or two is a summary of the evidence. The next following pages are references to the evidence by volume and page number of each doctor who gave evidence with respect to a child, and a note where a doctor did not give evidence with respect to a child, and the last page contains the toxicological data and a note of the evidence of the pharmacologists, where evidence was given.

So if you look at the Woodcock baby you see the first two pages which are our summary of the evidence, a note of all the evidence, all the





C.6

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medical evidence which, in our respectful submission, relates to that baby. On page 5 the toxicological data appearing raw and the pharmacological summary.

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Now, let me tell you that this document is prepared for our use and it is presented to you and to other counsel, for whatever assistance it may provide in helping us to deal with the voluminous evidence you have before you in this Inquiry.

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The summary, we have attempted to prepare, as dispassionately as we can. You will see from place to place that it contains material that is argumentative, that is the kind of material I would make to you in oral submission, but for the most part we have attempted to keep it as objective as we can.

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If we failed in that regard in any particular it is not a failure of design and you will understand, well, that is the Hospital making its submission to me rather than anything else.

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There is one other observation to make about it and it is this: we have used throughout the vocabulary of the experts and the vocabulary that Commission counsel has used: probable death, probable murder, high suspicion, low suspicion, no





C.7

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suspicion. We have used that vocabulary because that is the vocabulary of the evidence. I wouldn't want you to think that the repetition of that vocabulary undercuts at all my submission to you, that you can not make findings in this case on the basis of suspicion. Therefore, you will understand that where our summary suggests that the death is of low suspicion or high suspicion, that is a case in which, in our respectful submission, you cannot make a finding with the required assurance.

Now, there is one correction to be made, Tab 16, dealing with the baby, Volk.





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I am told by Ms. Thomson that I shouldn't say there is one correction, I should say there is a correction, and no doubt Ms. Cronk and others will discover others and it will be brought to your attention. This is our document for our assistance and really presented to the Commission and other counsel because I can save reading it thereby, and in the hope that it will represent a convenient way of collecting in one place all the medical and pharmacological evidence on each child. The correction is at Tab 16, the baby Volk, page 3 under Toxicological Data, the note at the bottom:

"Within range of concentrations reported in skin tissues of infants after digoxin toxicity."

Should be:

" ... after digoxin therapy."

Now I am not going to take you through most of these cases. I now want to ask you to look at Mr. Lamek's categories, and I propose, if you will permit, to go through them one by one by category. His Categories 1 and 2 encompass the Babies Cook, Miller, Pacsai, Estrella, Hines, Lombardo and Belanger, and in each of those cases there was and is in my respectful submission





D.2

1  
2 toxicological data when taken alone, absent the  
3 kind of neutral factors that I have been discussing,  
4 permits you to form a conclusion with two  
5 qualifications.

6 In other words, these are the cases  
7 where it will be for you to say whether the conclusion  
8 should be drawn, but these are cases where there is  
9 a foundation, a scientific foundation for decision-  
10 making with two reservations. If you made a  
11 decision with respect to those babies, no one could  
12 say that it was based on irrelevant material, or  
13 that it was based on foundations of sand. Whether  
14 you make it or not is your responsibility of course,  
15 sir, but there can be no scientific criticism at  
16 this stage of our learning on your capacity to make  
17 a finding in respect of those two categories.

18 Now the qualifications are the  
19 Baby Estrella for the reasons I have already given  
20 you this morning, so I would remove Estrella from  
21 that list, because in my respectful submission there  
22 is little foundation for finding in the case of  
23 Estrella without reference to neutral factors.

24 With respect to Hines, Lombardo and  
25 Belanger, I say that you can find that digoxin,  
unprescribed, was administered to these babies.





D.3

1  
2 There is no foundation, as Dr. Kauffman says, to  
3 conclude that they died as a result. But with those  
4 two qualifications I have nothing else to say about  
5 the Categories 1 and 2, except to say this: that  
6 not only is there a foundation of adequate and  
7 securely known toxicological data in those cases,  
8 but there is, and this in my respectful submission  
9 takes us back to our mulberry bush, but it is  
10 important, there is a general concurrence of  
11 scientific opinion, and therefore you can have  
12 regard to that. In no other case in this Inquiry,  
13 for reasons that are demonstrable can that be  
14 given.

14 Now, when you come to - I will leave  
15 Category 3 which are the babies which Mr. Lamek  
16 says died of natural causes.

16 In Category 4 we are dealing with  
17 Thomas, Gionas, Inwood and Gardner and these are  
18 cases where Mr. Lamek says --

19 THE COMMISSIONER: Wait just a second,  
20 Gardner, Inwood, Gionas and Thomas, yes, all right.

21 MR. SCOTT: That was the category  
22 in which Mr. Lamek said there was some toxicological  
23 evidence which taken with the pattern and the common  
24 threads could lead you to a conclusion. In my  
25





D.4

1  
2 respectful submission it is no satisfactory  
3 foundation for conclusions being drawn in these cases.  
4 If you take the baby Thomas first, by turning to  
5 Tab 26.

6 THE COMMISSIONER: Yes, just one  
7 second, Tab 26?

8 MR. SCOTT: Yes, sir. This was a baby  
9 that died at nine days of age. Dr. Rowe testified  
10 that the child had a cardiac defect which in the  
11 normal course of events leads to inevitable death.  
12 The child could have died at any time. The terminal  
13 events were sudden and rapid with vomiting,  
14 arrhythmias, bradycardia and ventricular fibrillation.  
15 This was consistent with both the child's anatomical  
16 condition and digoxin intoxication. There is nothing  
17 there that provides the foundation for a conclusion  
18 in favour of foul play.

19 Dr. Fay reported that there could  
20 only be a very low suspicion.

21 Dr. Hastreiter reported that the  
22 child had a lethal form of heart disease and the  
23 clinical course and terminal events were more or  
24 less expected. There was in Dr. Hastreiter's opinion  
25 only a small probability that is a new term of  
phrase, a small probability of digoxin overdose.





D.5

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2 Dr. Nadas reported that the child's  
3 prognosis was poor and the timing of her death was  
4 unexpected but consistent with clinical status, and  
5 also consistent with digoxin intoxication.

6 The toxicological data is from fixed  
7 tissues and therefore inconclusive in the view of  
8 the experts I referred to this morning. There simply  
9 is, in the case of Baby Jennifer Thomas, no  
10 satisfactory foundation upon which you can draw a  
11 conclusion unless you are prepared to heed the  
12 suggestion of your counsel to take into account  
13 these common threads, which in my respectful  
submission are irrelevant.

14 If you would turn to Baby Gionas at  
15 Tab 30. This baby died at 46 days of age. The  
16 clinicians believed that the baby died from natural  
17 causes. She had two major sets of defects and had  
18 undergone surgery. She remained in congestive heart  
19 failure following surgery. Two days before her  
20 death, the issue of digoxin toxicity was raised  
21 because of vomiting and the EKG strip. A level of  
22 1.2 was produced. Nonetheless, as with many of these  
23 children, the manner of her death was felt to be  
24 both consistent with digoxin intoxication and her  
25 clinical status, the neutral factors.





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The toxicological data comes from exhumed tissues only and is therefore inconclusive. The experts had the following to say: Dr. Fay said there was nothing unusual in her course and that death could be attributed to natural causes. In testimony, the notes of which are at the back, he stated that it would not be sensible to conclude that this child died of digoxin intoxication.

Dr. Hastreiter noted that the child got into some difficulty after digoxin had been held. The child was a good example of the delicate balance needed between prescribing the drug for its benefits and risking a toxic reaction.

Dr. Nadas noted that the child's prognosis was guarded and that the timing of her death was unexpected but consistent with her clinical status, also consistent with digoxin intoxication.

Dr. Kauffman ranked this child as low suspicion for digoxin involvement because of a lack of data.

Dr. Mirkin commented that this was "not a patient with sufficiently strong evidence for toxicity".

In my respectful submission there is simply on this record, without considering the





D.7

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relevant factors, no justification for the conclusion  
that Barbara Gionas died as a result of digoxin  
involvement.

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Now the baby Inwood is dealt with --

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THE COMMISSIONER: What are you asking  
me to find with respect to Baby Gionas, nothing, is  
that really what you are saying, that I should make  
no finding? You are not suggesting that I should  
find she died a natural death?

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MR. SCOTT: I think you can in some  
of these cases but I don't think it is necessary.

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THE COMMISSIONER: I just want to know  
what your submission was, what shall I do, if I accept  
everything you say about Gionas, should I say I just  
can't tell you?

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MR. SCOTT: Yes.

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THE COMMISSIONER: Or should I say -  
you are not suggesting there is any evidence pointing  
towards a natural death?

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MR. SCOTT: Yes, there is, I think  
the evidence in the Gionas case, almost all of the  
evidence points to a natural death but I am not  
asking you --

THE COMMISSIONER: She was a sick baby.

MR. SCOTT: Yes.





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THE COMMISSIONER: Sick babies don't always die.

MR. SCOTT: No, but sick babies quite often die a natural death.

THE COMMISSIONER: That's right.

MR. SCOTT: What I am saying is there is lots of evidence that points to a natural death. My concern --

THE COMMISSIONER: But there is the same kind of evidence, certainly in the case of Gionas, points to digoxin toxicity, because it could be either, it could be either, you say these facts are all neutral?

MR. SCOTT: Yes.

THE COMMISSIONER: And you see Mr. Lamek's point was that ordinarily we don't think of this sort of thing, we don't think of digoxin toxicity, but there have been some children who were poisoned and we have to think about it, and therefore, what do I say? If I accept your argument what do I say about Gionas? Do I say nothing, or - obviously you want me to say-it would be unsafe to say she died of digoxin poisoning. I am not to say there is some reason for suspicion because all these matters are neutral, you want me then to say --





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MR. SCOTT: I think you draw the conclusions where you safely can, if you can't draw safely from a conclusion --

THE COMMISSIONER: What do I do, I do nothing.

MR. SCOTT: You don't draw a conclusion.

THE COMMISSIONER: Yes, all right. I leave the page blank, or I leave the conclusion blank, what do you want me to do?

MR. SCOTT: Again it seems to me that your prime function is to deal with reality, the suspicions about these babies and the manner of their dying have been voiced by the Police, have been the subject of a preliminary inquiry, have been discussed constantly on television and radio. The purpose of this exercise, and this is fundamental to our submission, is to have you determine what you can as a matter of knowledge, and if you can't, if at the end you only have a suspicion, which is what we started out with, it is of no assistance with the greatest respect, to hear that repeated. We want to know what we can know. If we can know that the baby Gionas, or the baby Cook died of digoxin involvement you will tell us. If in the end we are





D.10

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left with suspicions then you will have to tell us we cannot know what happened to that baby, and I echo what Mr. Lamek said at the end --

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THE COMMISSIONER: You have answered my question, that is all that you want me to say, you cannot determine what happened to the baby?

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MR. SCOTT: Yes.

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THE COMMISSIONER: Some people might read that as saying I have some suspicions but that will be reading between the lines, and you say I shouldn't say that. If I knew, if I were satisfied that the child died of natural causes I should say that, should I not?

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MR. SCOTT: Yes.

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THE COMMISSIONER: Even if I worked that out concerning all the factors some of which may be neutral?

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MR. SCOTT: No.

THE COMMISSIONER: If I reached the conclusion that the child died of natural causes should I say that?

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MR. SCOTT: No, you can't in my respectful submission rely on neutral factors.

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THE COMMISSIONER: No, no, as I say, I consider all of the matters and if I reach the





D.11

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conclusion the child died of natural causes I am to say that. If I reach the conclusion the child died of digoxin poisoning, I am to say that?

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MR. SCOTT: Yes.

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THE COMMISSIONER: And if I can't be certain one way or the other I am to say nothing?

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MR. SCOTT: Yes.

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THE COMMISSIONER: I can give my reasons but I say nothing?

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MR. SCOTT: Yes. But you are not going to be in the business of proliferating suspicions.

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E-1

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It seems to me that you are being asked to do what nobody else has been able to do, to say what we can know. That is what we need. We want to know what can be demonstrated. We do not need somebody else to tell us what the suspicions are. We want to know what can scientifically and medically be demonstrated, if anything, and I have said there are some catagories where you may be able to make answers. But the idea, for example, that in the case of the Baby Gionas where all medical testimony is of low suspicion that you would be able, even with the pattern and all the rest of it which I say is irrelevant, to conclude that that baby died of digoxin at all just in substance boggles the mind.

THE COMMISSIONER: I agree. If all I see is no suspicion it would be kind of a peculiar Commissioner who would say on the basis of all of this evidence I think the baby was poisoned.

MR. SCOTT: But you see what Mr. Lamek does, and it took me a while because I am slow, to figure out how he got the babies into these various categories. But even I was able to figure it out, and the he got the babies into the various categories was he really went over the evidence and said, if the doctors are unanimous that it is natural causes, if





E-2

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all five of them in that vote vote natural causes  
I will tell the judge it is natural causes. If  
one of them says it is low suspicion, I will say  
it is suspicious, even though the other four may  
say it is not, or the other three. That is establishing  
two rules for the determination of one issue. If  
unanimity is what is going to be required before  
natural causes is found as a fact then unanimity  
should be required before digoxin overdose is found  
as a fact, which is of course my submission. It  
seems to me, if the report is to have the validity  
we want and you expect it has to be consistent.

I must move along because I want to  
leave Mr. Ortved some time. The next baby in this  
category four is the Baby Inwood with whom I have  
dealt but the summary for Kristin Inwood is at Tab 33,  
and this was the 491 reading about which I made  
submissions earlier this morning. What Mr. Lamek  
does is he takes fixed tissue readings to corroborate  
the 491. Zero plus zero equals five, It is just an  
unreliable exercise.

THE COMMISSIONER: No zero plus four  
equals five, I think, if you have it properly.

MR. SCOTT: Zero plus four equals five?

THE COMMISSIONER: If you want to say it,  
not zero plus zero.

MR. SCOTT: All right.





E-3

1  
2 THE COMMISSIONER: Because there  
3 is something in the serum.

4 MR. SCOTT: He is going to have  
5 difficulty persuading you that zero plus zero  
6 equals five, or even that zero plus four equals  
7 five. All of us know that you cannot add apples  
8 and oranges and get a practical useful result  
9 He has the 491. He is troubled about it and he  
10 says having got that I am going to fortify it.  
11 Fortify it with what? With evidence which the  
12 experts say is inconclusive. That is not a corroborative  
13 principle and that is what he does with the Baby  
14 Inwood.

15 With respect to the  
16 Baby Charlon Gardner, her summary is  
17 found at Tab 34 and you will recall Mr. Lamek in  
18 his catalogue of suspicion calls this one low  
19 suspicion and the only evidence that can adduce  
20 any suspicion is the fact that this was the baby  
21 where Sui Scott said that she came back after the  
22 break and the child was worse and subsequently  
23 expired. Actually apart from the pattern, the  
24 common thread, that is the only evidence upon which  
25 you can rely and that is, in my respectful submission,  
simply inadequate for the task. The toxicological





1  
2 data on this child came from fixed tissues.  
3 Dr. Fay reported that the death could be attributed  
4 to natural causes here even though the homicide  
5 team apparently concluded at that meeting in  
6 September that it was probably murder. Dr. Hastreiter  
7 said there was only a small probability of a massive  
8 digoxin overdose and Dr. Nadas reported that the  
9 prognosis of the child was poor, that the timing of  
10 her death was expected and consistent with clinical  
11 status and as well, as he always seems to have  
12 said except in about three cases, consistent with  
13 possible digoxin intoxication. In my respectful  
14 submission there is a concensus of the medical authority  
15 that this child died as a result of natural causes.  
16 You cannot make a finding that she died of digoxin  
17 overdose.

18 That deals with the fourth category.  
19 The fifth category which I think I call, and  
20 Mr. Lamek came close to calling, the category of  
21 nagging suspicion comprises the Babies Woodcock,  
22 Dawson, Gage, Volk, Lutes, Onofre, Warner, Manojlovich,  
23 and Bilodeau, and what Mr. Lamek said here was that  
24 there was some toxicological data in fixed or exhumed  
25 tissues. He took that evidence that I say is  
inconclusive with the circumstances of their dying,





*I didn't  
suggest that  
G. make such  
a finding!*

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2 unexpected, sudden. Now if you look at the Baby  
3 Woodcock, at Tab 1, the first fact we concede is  
4 that the death of this baby was unexpected and  
5 sudden. He also agreed that there was no apparent  
6 explanation for it which is why the Hospital reported  
7 it to the coroner. But those facts do not support  
8 a finding of digoxin involvement.

9 The toxicological data was obtained  
10 after exhumation and is felt by the experts to  
11 be inconclusive. Dr. Fay thought toxicity was  
12 unlikely and when being cross-examined by Mr. Strathy  
13 he changed his rating to natural causes. Why?  
14 Because the toxicological data did not support  
15 concern. Dr. Nadas noted that the timing of the  
16 death was unexpected and inconsistent while the  
17 nature of the terminal events were consistent. I  
18 have a note of Dr. Rowe's and Dr. Freedom's evidence  
19 and Dr. Hastreiter felt that the probability  
20 of overdose was good. In my respectful submission  
21 you have a clear conflict between the experts and  
22 it simply is not open to you to make an appropriate  
23 finding.

24 THE COMMISSIONER: It is a new  
25 proposition but I will accept it for the purposes  
of this argument.





E-6

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MR. SCOTT: Let us take this case.

If you are going to accept Dr. Hastreiter in the case of Baby Woodcock I presume that you are going to evaluate his evidence in some fashion and reject Dr. Fay's conclusion. If you pursue Mr. Lamek's approach in the next case you are going to have to adopt Dr. Fay and reject Dr. Hastreiter.

THE COMMISSIONER: I can do that if I want to. I have to get some solid reason for doing it.

MR. SCOTT: I mean if you are going to reject Dr. Hastreiter on the grounds that he doesn't know what he is talking about in the Woodcock case, are you then going to be able to say that in the next case he does know what he is talking about?

THE COMMISSIONER: I have to justify it if I'm going to do that but you say I cannot do it, that is all I am saying. I can do it and you may not like it and if there were an appeal they might say it is a pretty slopy business, but I can do it.

MR. SCOTT: My friend, Eric Murray, is always lecturing me about the distinction between "can" and "may" and I never get it right. I should be





E-7

1  
2 saying you are entitled to do that but you will  
3 not want to do it because on balance it provides  
4 an insecure foundation for your findings. Now  
5 when I say "can" from here on, which I will try  
6 to avoid, I hope, sir, you will read it as that.

7 THE COMMISSIONER: I was not giving  
8 you as dramatic a lesson as Murray might but I'm  
9 merely saying that it is a legitimate traditional  
10 tool to accept the evidence of one witness in one  
11 part and another witness in another and I intend  
12 not necessarily to do that but to hold that solution  
open unless you can show me that I may not.

13 MR. SCOTT: I have made my submission  
14 on that and will simply repeat once more that it  
15 seems to me on the fringes of science with the modest  
16 amount of raw material that is present in these  
17 cases where there is a legitimate diversion of scientific  
18 view about the central question in issue - this is  
19 not divergence of view about some collateral matter,  
20 it is divergence of view, profound, among well-qualified  
21 experts on the very issues that you have to decide.  
22 It seems to me that, in those cases, there will  
23 always be uncertainties unless you do what Mr. Lamek  
24 does when he comes to the natural causes babies and  
25 say I am going to act where there is a unanimous view





1  
2 or nearly unanimous view. That is what he does  
3 in some of the cases. He does not do it in pursuit  
4 of the murder theory, and I think you should, and  
5 I ask you to do it.

6 Baby Dawson is at Tab 5. This is  
7 a baby in which tissue samples were either exhumed  
8 or fixed. Dr. Cutz thought it was clearly a natural  
9 causes death. Dr. Fay thought it should only have a  
10 low suspicion and while testifying he re-evaluated  
11 that and thought it should be put in the natural  
12 causes category. Dr. Hastreiter noted that the child  
13 started to deteriorate rapidly 24 hours prior to  
14 death but that her death was sudden and unexpected.  
15 In his report he stated the probability of massive  
16 digoxin overdose was fair. On examination he was  
17 asked if the symptoms of lethargy, vomiting and  
18 floppiness which had exhibited themselves during  
19 the last five days of this child's life could have  
20 resulted from a toxic dose of digoxin, he said he  
21 did not think this was probable. In addition, the  
22 toxicological data is not really supportive of the  
23 Dawson child having received a massive dose. He  
24 came a very substantial distance to change his mind,  
25 as Dr. Fay directly did. It seems to me there is  
no evidentiary foundation for an appropriate opinion





E-9

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2 here.

3 The next in this category is  
4 Baby Gage at Tab 13, and Brian Gage died in September  
5 at 29 days of age. This was the baby you will recall  
6 who received the double dose in error. The  
7 toxicological data was based on exhumed tissues alone  
8 and, in my respectful submission, as I think the  
9 experts thought, inconclusive.

10 Dr. Fay noted that the nature of  
11 the child's heart disease made him liable to die  
12 suddenly. The child had a high digoxin serum reading  
13 on the day before his death. On reflection, Dr.  
14 Fay put the child in his low suspicious category.  
15 Dr. Hastreiter felt that the infant was relatively  
16 stable and the death unexpected. He originally  
17 felt that the probability of digoxin overdose was  
18 good. In testing however he commented that the  
19 child was very sick and could have died naturally.  
20 He felt that the cause of death was not forthcoming  
21 from the chart and that the infant did not appear  
22 to be at imminent risk of death. On cross-examination  
23 he agreed with Dr. Rowe's evidence of this child  
24 and Dr. Rowe's testimony was that while the precise  
25 cause of death was unclear it was most likely due  
to a toxic episode.

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Dr. Kauffman ranked the child on the lower scale of probability because of the lack of data and also because of the course of the terminal event.

Dr. Mirkin was not substantially suspicious of digoxin involvement and connected the elevated digoxin level in the days before the baby's death with renal insufficiency, a case where all of the expert opinion really is that this is low suspicion and where a finding cannot, on any firm foundation, be made.

Now, the next in this category was the Baby Volk and Mr. Lamek in his submission, accepts that you cannot make a finding here or accepts that the death was a natural one, so I have nothing. That view is again a view where all the experts appear to be consistent and I have nothing to say about it.

The next baby in Mr. Lamek's category five is Matthew Lutes and again there is no toxicological data. Mr. Lamek agrees that this was a natural death. I have nothing further to say about that.

I pause here, though, to comment that Lutes, the Baby Lutes, is an interesting example





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2 because if there was ever a baby, for whom the  
3 pattern, the common threads would show digoxin over-  
4 dose, it is the Baby Lutes. The team was on, it was  
5 early morning, it was a sudden death, according to  
6 Dr. Rowe, and yet, Mr. Lamek says that the pattern  
7 does not play in the case of this child. In other  
8 words, again, the pattern is being applied as a make-  
9 weight to support a conclusion. It is not being  
10 applied as a pattern, it is being applied as a make-  
weight.

11 If you conclude, as Mr. Lamek asks  
12 you to, that Lutes died of natural causes, what do  
13 you make then about the pattern. But I have nothing  
14 further to say about -- I think I have nothing further  
15 to say. Ms. Thompson points out that I should correctly  
16 say that there is toxicological data, but that in  
17 the circumstances Mr. Lamek says that that data does  
not support dig. involvement.

18 THE COMMISSIONER: The reading is  
19 2.1.

20 Yes, go on.

21 MR. SCOTT: I agree with respect to  
22 Matthew Lutes, with Commission Counsel's submission  
at base, so I have nothing more to say about it.

23 The next baby in his Category 5 is  
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2 John Onofre at Tab 18. This baby died at 18 days of  
3 age and again the toxicological data is from exhumed  
4 tissues and is thus inconclusive. Again, the weight  
5 of expert testimony is entirely inconsistent. Dr.  
6 Phillips' testified that at autopsy this child was  
7 seen to be the victim of many illnesses and there  
8 was ample cause for death.

9 Dr. Fay noted that the sepsis in the  
10 child may have been significant, but that dig. toxicity  
11 had to be considered, because of the sudden onset of  
12 arrhythmias in a relatively stable baby. He concurred  
13 that the autopsy findings provided however a reasonable  
14 explanation for the child's death.

15 Dr. Hastreiter classified this child  
16 as a probable murder, because of the sudden deterioration.  
17 He did not find that the autopsy findings explained the  
18 suddenness, unexpectedness, of the death, although  
19 he found both Dr. Freedom's and Dr. Rowe's opinions  
20 reasonable.

21 Dr. Nadas noted that the child's  
22 prognosis was guarded and the timing of his death  
23 was unexpected and inconsistent, but, as he says, was  
24 consistent with digoxin intoxication.

25 Dr. Kauffman felt that there was  
insufficient data to allow any commentary about digoxin





1  
2 in this child.

3 Dr. Mirkin suggested that the cause  
4 of death was either due to arrhythmias or infection.  
5 So what you have really is you have three or four to  
6 one. If you look to opinion outside the Hospital it  
is three to one against digoxin intoxication.

7 THE COMMISSIONER: All right. It is  
8 opinion outside of the Hospital, but we are not  
9 considering Nadas then I guess.

10 MR. SCOTT: You see, Dr. Nadas was  
11 not called to give evidence, as you know.

12 THE COMMISSIONER: No.

13 MR. SCOTT: And we are, therefore,  
14 confronted with his one sentence evaluations in the  
15 formula that CDC used. He says, and we agree, there  
16 can be no doubt that almost all these babies died  
17 in circumstances consistent, or with clinical status,  
18 but consistent with digoxin intoxication. Now, if,  
19 in this case Dr. Nadas says in his opinion, which  
20 there was no examination, of course, that it was  
21 inconsistent with clinical status, but consistent  
22 with digoxin toxicity and special concern. I count  
that as a neutral, but if you want to put him on the  
plus side --

23 THE COMMISSIONER: He is certainly on  
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the plus if he says it is inconsistent or there is  
clinical condition or consistent with digoxin.  
It is hardly neutral, do you think?

MR. SCOTT: It seems to me it is close  
to neutral. Look what you have? You have Dr. Fay  
who comes and gives evidence.

THE COMMISSIONER: That is true, but  
I am saying what Dr. Nadas was saying was not neutral.

MR. SCOTT: I will give Mr. Lamek  
Dr. Nadas and then it becomes three to two instead of  
three to one.

THE COMMISSIONER: Hastreiter and  
Nadas on the one side. Who do we have on the other?

MR. SCOTT: You have got Dr. Fay,  
you have got Dr. Kauffman and you have got Dr. Mirkin.

Look at what Dr. Kauffman says in the  
summary. That there was insufficient data to allow  
any commentary about digoxin in this child. I guess  
I should be railing at him: Why don't you draw a  
conclusion. I want to know, tell me about your  
suspicions. He would say, no, there is insufficient  
data. I can't. That is the thrust of our single  
submission to you, sir, that where there is insufficient  
data you just have to say so. That is all you can  
do and that Dr. Kauffman represents --





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2 THE COMMISSIONER: He says there  
3 is insufficient data. He is saying what you would  
4 like me to say.

5 MR. SCOTT: I didn't say it was a  
6 vote for innocent death. I said that there are two  
7 if you include Dr. Nadas who have a suspicious view  
8 and three who don't. I am not going to be suspicious  
9 of a baby's death when there is no data from which I  
10 can draw a suspicion.

11 THE COMMISSIONER: Kauffman is a  
12 pharmacologist. That is why he wants that kind of  
13 data. Hastreiter is a cardiologist, so he uses  
14 the data that is familiar to him and reaches a  
15 conclusion that the child died of digoxin toxicity.  
16 Surely we agree there is no toxicology with this  
17 child. That is why Kauffman said I don't reach any  
18 conclusions, because Cimbura would be the same way.  
19 He would say I can't reach any conclusion either.

20 MR. SCOTT: Yes, but Dr. Hastreiter  
21 relies, and you will have to assess this, on the  
22 suddenness of the death.

23 THE COMMISSIONER: Yes.

24 MR. SCOTT: But yet in cases like  
25 Matthew Lutes where everybody concedes the death  
is sudden, Mr. Lamek says oh, that is natural causes,





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2 so the suddenness is again a variable factor that  
3 comes to play in some cases and not in others.

4 THE COMMISSIONER: It makes a difference  
5 how stable the child was before. If the child was on  
6 a downward path and suddenly dies that is one thing.  
7 If the child seems to be improving and/or was totally  
8 stable then suddenly dies it is another thing.

9 MR. SCOTT: I must say on the Lutes,  
10 Mr. Lamek is always full of surprises for me, but in  
11 the Lutes case where you have a statement by the  
12 clinicians that the death was sudden and where you  
13 have all those common threads that Mr. Lamek is talking  
14 about, the team in the middle of the night, the ward,  
15 he says, oh, that is natural. Then the next case  
16 where you have the common threads and the suddenness  
17 he says that is highly suspicious, that is a nagging  
18 suspicion.

19 This, in my respectful submission,  
20 is a scientific exercise and you will not want in the  
21 end to allow it to be governed by those kinds of  
22 considerations.

23 Let me move on, if I can, sir.

24 THE COMMISSIONER: You can if you like.  
25 It is now quarter past 11. How long will you be?

MR. SCOTT: I think I will be 20  
minutes and I would like to break now.





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THE COMMISSIONER: Yes, all right.

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Let's break now for 20 minutes.

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---Short recess.

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THE COMMISSIONER: Yes Mr. Scott.

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MR. SCOTT: Mr. Commissioner, the last three babies in Mr. Lamek's category 5 with which we have been dealing are the babies Warner, Manojlovich and Bilodeau. While I may have something to say, if necessary, I agree with Mr. Lamek's submission to you with respect to Warner and Manojlovich, which I understand that amounts to this; that you should not conclude that their deaths were occasioned by digoxin because of the circumstances of the case. That being his position I have nothing further to say until I hear other Counsel.

With respect to the Baby Bilodeau, that baby's summary is at Tab 3, and the toxicological data was exhumed tissue and is therefore in my respectful submission inconclusive. The clinicians at the Hospital diagnosed the child as having a serious congenital heart disease but felt that the child died a little sooner than expected. Dr. Rowe felt that the child was deteriorating before death and Dr. Rose concurred that although at the outset of terminal events was sudden, it was not surprising that the child's death could be adequately explained by his cardiac condition.





G-2

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2 Dr. Fay confirmed the serious  
3 congenital heart disease of the infant and stated  
4 that on the basis of toxicological data retrieved  
5 after exhumation any suspicion of digoxin toxicity  
6 would be very low. While testifying before you,  
7 and the note of his evidence is at the back of  
8 this summary, he was quite prepared to now put the  
child in the natural causes category.

9 Dr. Hastreiter stated that this was  
10 an extremely ill infant with a continually deteriorating  
11 clinical status. In cross-examination he stated  
12 that although he first felt that cause of death was  
13 likely natural, he could not rule out murder completely.

14 Dr. Nadas stated that the timing of  
15 the event was expected and consistent with clinical  
16 status although the nature of the terminal events  
was consistent with possible digoxin toxicity.

17 Now on that score Dr. Nadas it seems  
18 to me is truly neutral. Dr. Fay is against digoxin  
19 involvement and says it is natural causes. Dr.  
20 Hastreiter says he first thought it was natural but  
21 now can't rule out digoxin involvement and that the  
22 data, the toxicological data is inconclusive and  
23 I say there is no foundation of the required type  
24 for a conclusion about the death of Baby Andrew Bilodeau.  
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Now in dealing with this category I have from time to time said that there is no toxicological data, and I take it that has caused some excitement. There is of course and let me just go through the babies so you will see what it is. In Woodcock it is exhumed tissue. In Dawson it is fixed tissue. In Gage it is exhumed tissue. In Volk it is frozen tissue. In Lutes it is fixed tissue. Onofre it is exhumed. In Warner it is fixed. Manojlovich there is none post mortem. Bilodeau it is exhumed.

Now when I say there is no toxicological data, what I should say is that there is that data but for reasons I have given this morning that must be regarded as inconclusive and insufficient evidence upon which you can act.

Now, the last category with which I ask you to deal is Mr. Lamek's category No. 6. In this category there is no toxicological data of any type, and it includes the Babies Taylor, Shrum, Velasquez, McKeil, MacDonald and Gosselin. Mr. Lamek said that the elements that generated suspicion and invoked the conclusion from you were the suddenness and unexpectedness of the child's death. The fact that the autopsy report was unable





G-4

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2 to pinpoint a cause of death; or the fact that there  
3 was surprise at the death on the part of clinicians,  
4 and that one or all of those factors entitled you  
5 to draw the conclusions he recommended from case  
6 to case. Now, I have dealt with each of those  
7 much earlier in this submission in support of the  
8 proposition that there are neutral factors and  
9 cannot be considered by you.

10 I think it may be useful to look  
11 very briefly at the summaries. The Baby Taylor  
12 is under Tab No. 4; and the clinicians were of the  
13 view that the cardiac diagnosis adequately explained  
14 the child's death. They recognized that he may,  
15 however, have died a little sooner than expected.  
16 The doses administered of digoxin were found to be  
17 appropriate.

18 Dr. Fay confirmed the severity of  
19 the child's disease but felt that the changes in  
20 the S.T. segment were significant. In testimony  
21 he stated that he had originally been of the opinion that  
22 Dr. Izukawa's note about digoxin, that is his  
23 review of the medications which he does routinely  
24 with every dying patient, indicated an inherent  
25 suspicion about the child. He subsequently stated  
that the anatomical diagnosis indicated a very  
severe disease and that these babies often die within





G-5

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the first weeks of life therefore he felt that the child's death could now be categorized as low suspicion.

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Dr. Hastreiter concluded that because the terminal episode was sudden an unexpected the probability of massive overdose was good. In testimony he stated - that was in his report - in testimony he stated that these children were prone to die suddenly but he felt that the clinical cause indicated a good probability of overdose. On cross-examination he agreed with Dr. Rowe's analysis of the child, but questioned the timing of the death as to whether or not the child was improving, he stated there were contradictions in the comments contained within the chart.

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Dr. Nadas noted at the time the child's death was unexpected but consistent with clinical status. The nature of the terminal events were consistent with special concerns.

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Dr. Mirkin acknowledged that due to the lack of toxicology of this child the clinical course and EKG tracings were the best evidence of digoxin intoxication. He acknowledged that this conclusion was inferential at best. He also agreed that the arrhythmias noted were consistent with the





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disease process as well as with digoxin intoxication.

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In my respectful submission it may be that Mr. Lamek made the same point. This is a case where the record and the evidence is so evenly balanced in support of one view of the other than it seems to me you would not be able to come to a satisfactory conclusion.

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Now the next baby is Dion Shrum, at Tab 8, who died at 57 days of age. Without taking you through it, Dr. Fay stated that there could only be a low suspicion and placed the child in the low category only because of the terminal arrhythmias.

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Dr. Hastreiter in his report noted that the probability of massive digoxin overdose was good, he felt that the post mortem examination did not reveal an obvious cause of death, although the type of terminal events may occur with the child's diagnosed effect. In testimony he stated that his only concern was that the heart block occurred some three hours following catheterization rather than immediately following the procedure. However, he stated that he was now prepared to change his view to low suspicious. This child was as well noted as one of the examples of why a





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legitimate divergence of opinion exists as to whether or not the death was expected or unexpected. I respectfully submit that there is no foundation in the case of Dion Shrum for reaching the conclusion that there is digoxin involvement in this baby's death.

The Baby Antonio Velasquez dealt with at Tab 11, a lot has been said about this baby and I don't intend to repeat it. I simply note that Dr. Fay says that the level of suspicion is low. Dr. Hastreiter said that the possibility should be entertained, but that the probability was only fair. I don't know where you weigh all that at the end, but the possibility should be entertained but the probability was only fair. Then in an exchange with your, sir, he came back and said that he stated that he would not place the child in the good probability category but he could not exclude the possibility.

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2 Dr. Nadas weighed in with the usual  
3 two sentences. Dr. Kauffman felt that it was highly  
4 unlikely that the drug which was at first indicated  
5 was in fact involved but he could not speak to the  
6 involvement of digoxin toxicity because of the lack  
7 of data. Dr. Mirkin agreed that there was no  
8 evidence of digoxin intoxication. He found that the  
9 symptoms were consistent with the presence of codeine  
10 and that this was confirmed by the positive effect  
11 of the first dose of naloxone. There was considerable  
12 concern as to the timing of the administration of a  
13 potentially lethal dose of digoxin and its inter-  
14 action with codeine and naloxone. Dr. Mirkin felt  
15 that if the lowered heart rate had been due to  
16 digoxin rather than codeine, the naloxone would not  
17 have been effective in reversing this phenomenon. He  
18 rated the probability of digoxin toxicity as 10 per  
cent and stated that it is unlikely that the death  
was caused by digoxin.

19 You are perfectly entitled to believe  
20 one or the other but I frankly do not understand how  
21 you can wade through successfully a case like that  
22 and conclude with the requisite assurance that digoxin  
23 was the cause of this baby's death notwithstanding  
24 that, as you have noted earlier, this is one of the  
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2 deaths that is the hardest to understand.

3 THE COMMISSIONER: It is completely  
4 impossible for me to understand. I have no idea  
5 what happened to this child. I do not believe,  
6 speaking perhaps out of turn, I do not believe this  
7 naloxine thing. It is just too strange. If I were  
8 asked to rate the chances of that being the cause of  
9 death I would put it at about 1 in 100, and that is  
10 practically taking it from the doctors themselves.  
11 They are grasping at straws.

12 MR. SCOTT: Medicine is full of  
13 mystery. You put that cause at 1 in 100. Dr. Mirkin  
14 puts digoxin at 10 out of 100.

15 THE COMMISSIONER: Then what did the  
16 baby die of?

17 MR. SCOTT: You cannot draw a  
18 conclusion. If you were able to draw conclusions  
19 about what the baby died of in every case you really  
20 would win the Nobel Prize because you would know an  
21 awful lot about medical science that is not yet  
22 revealed to us. I think this baby's death is just  
23 very difficult to understand and it may be that we  
24 will never understand it. But that does not lead  
25 to a conclusion about it. That leads to facing up  
to the reality that we do not understand it and





H.3

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2 cannot assign any better than the doctors can an  
3 appropriate reason for it. I do not regard that as  
4 a failure. I regard that as a realistic recognition  
5 of where we stand.

6 The baby McKeil at Tab 14, without  
7 taking you through it, it seems to me that this again  
8 is a case of low or medium to low suspicion without  
9 any toxicological data.

10 The baby MacDonald at Tab 19 to whom  
11 Mr. Lamek devoted some time, Dr. Fay noted in his  
12 report that there was a question of vagal reflex  
13 being responsible for cardiac arrest. He felt that  
14 digoxin intoxication had to be considered although  
15 the death was probably due to natural causes.  
16 Dr. Hastreiter, noting that the child's death was  
17 unexpected and the immediate cause of death unclear,  
18 there was a question of vagal reflex following a  
19 suction manoeuvre. On cross-examination he  
20 concurred that the explanation given by Dr. Rowe  
21 would be the most likely one to which a physician  
22 would resort. Dr. Hastreiter continues to suspect  
23 the involvement of digoxin in the child's death and  
24 Dr. Mirkin said that there was nothing from which he  
25 could conclude that digoxin was involved. In my  
respectful submission this is another low suspicious





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case about which no decision can at this stage of time or knowledge be made.

The last baby in this category is Real Gosselin, at Tab 20, and here Dr. Fay indicates that having reviewed Dr. Freedom's evidence this was the case where Dr. Freedom's letter to the referring physician was an exhibit and Dr. Freedom gave evidence about that and the response of the child to prostaglandin therapy. On the basis of that, Dr. Fay was prepared to place the child in the category of natural causes although he had still in the end some lingering doubt. Dr. Hastreiter testified that Real Gosselin was an extremely ill infant but that the abruptness of the terminal events was unexpected and that on the basis of Dr. Freedom's letter the cardiologist had no good explanation for the infant's deterioration and death. On cross-examination Dr. Hastreiter concurred with Dr. Rowe that the death was not as sudden as he had previously felt and that this type of baby can die suddenly. He stated that he could not totally eliminate digoxin as a possible cause. He rated it No. 1 for low suspicion. Dr. Mirkin believed that the death could now be categorized as expected as a consequence of poor response to prostaglandin. He believes that





H.5

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2 there was a low probability of digoxin intoxication  
3 in this child.

4 Now those are all the babies in  
5 Category 6. Category 7 was five babies in which the  
6 evidence was purely circumstantial. That is, they  
7 were babies who died on Wards 4A or 4B during the  
8 epidemic period during the night and Mr. Lamek I  
9 think, if I recall correctly, recommended to you that  
10 it would not be possible to draw any conclusion at  
11 all in these cases, and therefore I have nothing to  
12 say about them.

13 I simply close by observing that it  
14 is the position of the Hospital that you have an  
15 adequate record for determination insofar as present  
16 science and understanding and knowledge is concerned  
17 with respect to the babies in Categories 1 and 2  
18 with the exception of Baby Estrella and with the  
19 qualification I have suggested with respect to  
20 Lombardo and Belanger, that it may be open to you  
21 to conclude that unprescribed digoxin was received  
22 but because of the scientific difficulties about  
23 timing and causality, you may not be able to determine  
24 either that it caused death or if it was intended  
25 to cause death, whether it was deliberate. I should  
point out, as Miss Thomson has reminded me, that it





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is also a qualification with respect to Hines.

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With respect to the babies in the other categories, you have our submissions about the very severe constraints that are put upon you by the nature of the evidence. All the participants here have done their best to provide you with all that can be known and all that can be seen and all that can be read about this problem. It is our submission that it simply will endanger the utility of this much sought after report if we begin the exercise of escalating suspicions into assertions.

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Now, that is very troublesome, I recognize. It is troublesome for the doctors, the nurses and the parents. I think particularly of the parents of the baby Gosselin who have been present at this hearing from time to time and who are undoubtedly vitally concerned to find out what they can and to hear what you have to say about the death of their baby. That is an understandable reaction. But the continuation of the tragedy which has afflicted us for two years may be to say to people like Mr. and Mrs. Gosselin, we have shown you all we can, we have told you all we know and in the end we cannot reach a conclusion with the required degree of assurance even though if it were at all possible we would want to do so in order to ease your suffering.





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2 I know that the Hospital feels terribly concerned  
3 about that. This whole issue has been a horrible  
4 experience for those who work in the Hospital. Their  
5 hearts and souls are engaged in that effort and this  
6 has been very destructive of their motivation and of  
7 zeal, but they labour on and all we can say is that  
8 this is the best medical science can do to provide  
9 these parents with answers to these questions.

10 I have been much longer than I  
11 anticipated, but I want to thank you, sir, for your  
12 patience.

13 THE COMMISSIONER: Thank you, Mr.  
14 Scott.

15 Mr. Ortved.

16 ARGUMENT BY MR. ORTVED

17 MR. ORTVED: Just at the very outset,  
18 Mr. Commissioner, on behalf of Miss Chown and myself,  
19 I want to adopt and underline the remarks made at the  
20 commencement of Mr. Scott's address to you concerning  
21 the manner in which the hearing has been conducted,  
22 now extending over some 155 days. By that I mean that  
23 we have been impressed, as I am sure the members of  
24 the public have been impressed, with the courtesy  
25 which you have extended to our clients, in particular,  
as well as to all the witnesses who came before you





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2 and the reception that was afforded to Miss Chown  
3 and myself, in particular, and to all counsel here  
4 before you.

5 Certainly there is no member of the  
6 public and no parent, in particular, with whose  
7 position we sympathize in the extreme, who can feel  
8 otherwise than that the matters before you have been  
9 given the very fullest and fairest hearing.

10 Our submissions are directed to you  
11 on behalf of the 40 physicians at the Hospital for  
12 Sick Children and elsewhere now for whom we act.  
13 More specifically those doctors include the cardiologists,  
14 comprising the division of cardiology, who were so  
15 intimately involved in the care of the infants in  
16 question and for many of whom you have heard here and  
17 I advert to Dr. Rowe, Dr. Freedom, Dr. Fowler, Dr.  
18 Izukawa and Dr. Rose.

19 So also we appear here on behalf of  
20 the cardiovascular surgeons, from whom you have not  
21 heard, those gentlemen being Dr. Trusler, Dr. Williams,  
22 but whose care is also intimately balanced with the  
23 matters before you.

24 We appear on behalf of a number of  
25 pathologists who had the carriage of the autopsies  
which formed such a central matter for your consideration





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2 and some of whom you have heard from, including  
3 Dr. Phillips, Dr. Mancer, Dr. Becker and Dr. Taylor.  
4 It includes a number of other physicians, including  
5 biochemists, physicians in training or house staff,  
6 as they are referred to, being the residents from  
7 some of whom you have heard: Dr. Costigan, Dr. Kantak,  
8 Dr. Kobayashi, to name some and, lastly, we appear on  
9 behalf of the physician in chief, from whom you also  
heard, Dr. Carver.

10 Without singling out any of those  
11 individuals, Mr. Commissioner, I put it to you that  
12 you cannot have been other than impressed with the  
13 calibre, the expertise, the dedication and the  
14 integrity of each and every one of that group of  
physicians.

15 As Mr. Scott pointed out to you, we  
16 would ask that you consider our argument in tandem,  
17 as it were, with those matters addressed by Mr. Scott.

18 I adopt those submissions made to you  
19 by Mr. Scott. Happily you will hear not line by line,  
20 but specifically we are anxious to adopt his remarks,  
21 in particular, concerning the subjectivity of much  
22 of the evidence you have heard here, instances being  
23 the opinion concerning the diseased states of the  
24 children, the severity of those states, the prognosis  
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2 given those states and the deaths, as to whether they  
3 were expected or unexpected.

4 We specifically adopt Mr. Scott's  
5 submissions to you regarding the guidelines that  
6 should govern your decision-making process and, in  
7 particular, the burden of proof which you should apply  
8 to your job. I will not say other than that.

9 We adopt Mr. Scott's submissions to  
10 you regarding the manner in which doctors approach  
11 problems and, as has been --

12 THE COMMISSIONER: Before you go on,  
13 I didn't understand Mr. Scott to say there was a burden  
14 of proof. It will give you a balance of probability.  
15 It is the ones in between he has viewed as burden of  
16 proof, and if I can't be certain one way or the  
17 other I shouldn't say anything.

18 As far as determining whether the  
19 child died of digoxin poisoning or died of natural  
20 causes is the balance of probabilities. Will you  
21 accept that?

22 MR. ORTVED: I accept that with the  
23 caveat, which I consider to be bound up in that  
24 submission on the part of Mr. Scott, and that is to  
25 say that where you are unable to conclude on the basis  
of objective evidence that there was digoxin intoxication,





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you should err on the side of finding the child not  
to have been deliberately overdosed.

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THE COMMISSIONER: Yes, all right.

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MR. ORTVED: In terms of how doctors  
approach problems, as has been made manifest here,  
you will have seen how it is their custom to act only  
on evidence, to rely on evidence, to rely on each  
other and to learn from each other and you will have  
seen how doctors, I think unlike lawyers in many  
ways, when confronted with a problem which confounds  
them, are inclined to include more people into the  
consideration of the problem, as opposed to our  
system, which is sometimes to delegate the issue to  
a single person.

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I specifically adopt Mr. Scott's  
remarks to you concerning the neutral and the  
unhelpful nature of characterizations of deaths, as,  
for instance, sudden or unexpected.

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Lastly, I specifically adopt his  
remarks to you concerning the state of medical  
knowledge, circa 1980-81 concerning digoxin and  
bound up in that, his remarks to you concerning the  
fact that death due to digoxin intoxication will  
mimic death due to natural causes in a child with  
congenital heart defects.





1                   The crux of the concern to you is the  
2 cause of death. The evidence in respect of the  
3 various children has been reviewed by Mr. Lamek and  
4 Mr. Scott.

5                   I don't intend to re-review it for  
6 you. I rely on Mr. Scott's submissions concerning  
7 the individual children. We also rely on the additional  
8 information contained in the brief which has been filed  
9 before you.

10                  The evidence which the physicians feel  
11 should be taken into account, in addition to that  
12 canvassed by Mr. Lamek, is as set out in the remarks  
13 of Mr. Scott and as contained in our brief.

14                  Simply stated, in terms of how many  
15 children died of digoxin overdose, the doctors, for  
16 whom we act, don't pretend to know. As they told  
17 you, their view is that it would be confined though,  
18 to those cases where there is objective toxicological  
19 evidence, depending upon the extent to which that is  
20 supported by the expert pharmacologists and you  
21 accept that evidence.

22                  Mr. Scott made reference to Eric  
23 Murray. I hold him in high regard, but we do have  
24 some higher authority and I prefer his submissions  
25 regarding the Bernstein case and the evidence of Dr.  
Kauffman, in terms of analysing that issue.





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2 THE COMMISSIONER: Surely you will  
3 never get Mr. Murray to agree with a higher authority.

4 MR. ORTVED: Never would, but bearing  
5 in mind your fairness and great experience in these  
6 matters I know I can make that submission to you.

7 Of critical importance to doctors,  
8 separate and apart from your answer, in terms of  
9 whether none, some or all of the children under your  
10 consideration here died of deliberate overdose, is the  
11 issue of their actions in the context of those deaths.  
12 This is of equal concern to the physicians, be they  
13 surgical staff, medical staff, pathologists, bio-  
14 chemists, house staff.

15 I think it is fair to say that there  
16 has never been a group of medical personnel who have  
17 ever had their practices, procedures subjected to the  
18 sort of microscopic scrutiny that has occupied you  
19 for in excess of this past year. Furthermore that  
20 scrutiny comes in the context of the possibility that  
21 many deaths, which were treated by those physicians  
22 as being natural deaths at the time, may have been  
23 due to other than natural causes.

24 In my respectful submission to you  
25 it is of central importance to your assessment of their  
input, as to the cause of death, to understand their  
actions and their consideration of those deaths at the  
time.





J-1

DM/ac

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And secondly, it is of importance to the doctors and will come as no surprise to you that they are sensitive and concerned that there not be an inference drawn that their conduct is in any way wanting. Thus it is our submission that we are anxious to advance before you their views as to the condition of the patients and to explain their thought processes in relation to those patients so that their actions will be understandable.

Yesterday you made a comment at page 1012 of Volume 154, as follows:

" I am not at all sure it is any part of my mandate to take any position with regard to whether the doctors did or did not appreciate what was going on or should have appreciated it, ... "

I would just like to address that issue very, very briefly.

Your terms of reference, as yet unadulterated by any amendments, provides in ss3 and you probably don't need me to read this to you says:

" That you are to inquire into and report on and make any recommendations





J-2

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" with respect to how and by what means children who died in cardiac wards 4A and 4B at the Hospital for Sick Children between July 1st, 1980 and March 31st, 1981, came to their death. "

Those words probably have a familiar ring to them.

THE COMMISSIONER: Yes, the second date was what?

MR. ORTVED: March 31st, 1981.

THE COMMISSIONER: As you know we have amended this without permission from anybody, June 30th to March 22nd. No one raised an objection and I haven't had any motions, or notices of motions served upon me, a stated case to the Divisional Court, we just casually carried on with those two dates.

MR. ORTVED: You have heard the adage of counting your chickens.

THE COMMISSIONER: Yes.

MR. ORTVED: It does not do any violence to my submission to you. It is this, that a plain reading of that particular clause of your Terms of Reference would not appear, in my





J-3

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respectful submission to you, that you cover any

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analysis of the actions on the part of the doctors.

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Of course those Terms of Reference, Mr. Commissioner,

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don't stand alone and again I hate to bring up

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something that I know is not close to your heart,

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but they have been interpreted elsewhere.

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THE COMMISSIONER: Have they.

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MR. ORTVED: Which you may recall

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and the Court of Appeal, again familiar to you,

made this statement at page 15 of their Judgement:

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" In our opinion ... "

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And they are referring to the Order in Council and

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the restrictions placed upon you and it commences

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I suppose at page 14:

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" But the Order in Council specifically

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limits the Commissioner by forbidding

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him to express any conclusion of

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law regarding civil or criminal

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responsibility for a death or

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deaths. In our opinion, such a

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conclusion may be expressed by

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findings of fact which without more,

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when found against a named person,

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constitute a conclusion of criminal

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or civil responsibility. "





J-4

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2 And I think the position of that  
3 wording is of importance to the submission I am  
4 placing to you in answer to the particular question  
5 that you raised yesterday. I take the position  
6 that you are precluded from commenting adversely,  
7 or finding fact which constitute a conclusion  
8 amounting to a finding of civil responsibility on  
the part of any individual doctor.

9 Now that is a conclusion which in  
10 my respectful submission is supported by Mr. Lamek.  
11 He, in opening to you on June 4th, 1984 made the  
12 following comment at page 160, Volume 148, and I  
13 am paraphrasing but his reference at the bottom of  
that page is:

14 " My submission though is this,  
15 Mr. Commissioner: criticism of  
16 the Hospital or of the physicians  
17 or of the nurses ... "

18 And skipping a portion:

19 " ... it's not particularly relevant  
20 to the question upon which you have  
21 to report, how and by what means  
the children died. "

22 THE COMMISSIONER: There are a lot  
23 of other things going for you. I'm not supposed  
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J-5

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2 to cover the ground covered by the Dubin inquiry.

3 MR. ORTVED: I was going to come  
4 to that.

5 THE COMMISSIONER: I am sorry.

6 MR. ORTVED: My submission doesn't  
7 stand alone of course, it is, simply stated you  
8 have a very restrictive ambit for your consideration  
9 here. It is my respectful submission to you that  
10 the conduct on the part of the doctors is just  
11 not something upon which you should feel obliged  
12 to report.

13 THE COMMISSIONER: You are preaching  
14 to the converted at the moment so I don't think you  
15 need to say anything further, I have enough trouble.

16 MR. ORTVED: I think you do. In  
17 any event that interpretation that I put to you,  
18 and that you have indicated you probably share, and  
19 the comments of Mr. Lamak notwithstanding, I take  
20 the position that because the response on the part  
21 of the physicians is so inextricably bound up in  
22 the consideration of the deaths, some of which you  
23 may find to be due to other than natural causes,  
24 that I am obliged to address certain of their  
25 actions and their perceptions. I do this also,  
Mr. Commissioner, in the expectation that either directly





J-6

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2 or indirectly others may feel compelled to make  
3 submissions in that regard.

4 So I intend to focus my submissions  
5 on two broad areas of principle concern to the  
6 physicians. First, how did the doctors respond to  
7 the deaths as they were occurring? Now under that  
8 heading, I intend to canvass such areas as, first,  
9 their awareness of increased deaths; and second,  
10 the steps taken by the medical staff to examine  
11 the deaths and search for an explanation.

12 In addressing those issues I will  
13 be focussing principally on the meetings, the  
14 mortality and morbidity conferences which took place  
15 in the fall of 1980 and January 1981. I also will  
16 be canvassing the response on the part of the doctors  
17 on the weekend of March 21st, 1981.

18 Secondly, in terms of general areas that  
19 I intend to address, I will be speaking to the  
20 question of patterns on the ward. In this regard  
21 I will be focussing primarily on the question of  
22 an increase of deaths and "clusters" as an explanation  
23 for those increases.

24 Thirdly, canvassing the issue of  
25 pattern beyond an increase and whether the doctors  
should have been alerted to the pattern.





J-7

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2 THE COMMISSIONER: Is the pattern  
3 beyond the increase?

4 MR. ORTVED: I wanted to address  
5 the whole issue of patterns. In my respectful  
6 submission you have more than one pattern, you  
7 have a pattern of increased death, and you have a  
8 pattern which Mr. Lamek has adverted to at great  
9 length in terms of other factors that might influence  
10 your consideration.

11 Now, before I address each of those  
12 two issues, just let me put my general submission  
13 to you and it is this: throughout the epidemic  
14 period, it is my submission to you that the physicians  
15 treated the whole matter of the deaths that were  
16 occurring on the cardiac ward as a clinical problem  
17 capable of a clinical solution.

18 It is further my submission to you  
19 that without the benefit of hindsight and the  
20 accumulated knowledge that hindsight brings that that  
21 approach was a natural and a perfectly understandable  
22 one. That is to say that again I support the  
23 submissions to you on the part of Mr. Lamek to the  
24 effect that an innocent explanation was entirely  
25 reasonable and that you will recall again was in his  
opening to you on the 4th of June, 1984, in Volume 148,





J-8

1  
2 page 161, I suppose it starts on page 160:

3 " It is in my submission, doing the  
4 best I can to put myself in the  
5 context in which they were then  
6 looking at these deaths in the  
7 fall of 1980, is entirely under-  
8 standable that the medical and  
9 nursing staffs of a hospital would  
10 ascribe innocent explanations to  
11 the multiple deaths which occurred.  
12 The idea that something other  
13 than innocent deaths might be  
14 occurring would simply not occur to  
15 them. "

16 And I put it to you that is a very  
17 fair analysis on the part of Mr. Lamek. It is  
18 unreasonable to expect that doctors who function as  
19 epidemiologists, as investigators, or as expert  
20 pharmacologists while carrying out their day to day  
21 activities in a busy active care hospital catering  
22 to severely ill patients such as the Hospital for  
23 Sick Children, clearly, Mr. Commissioner, if there  
24 were deliberate intentional overdoses of digoxin  
25 administered to children on wards 4A/4B during the  
epidemic periods, the doctors at that time, at least





J-9

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up to the weekend of March 20th, 1981 were not  
aware of it.

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Further, you cannot consider the  
doctors' conduct other than in the context of the  
fact as already averted to by Mr. Scott of the  
severely compromised states in which all of these  
children found themselves. Save, perhaps, Jordan  
Hines, depending upon your interpretation and  
perhaps Kevin Pacsai. In sum and substance there  
is no death in my respectful submission to you  
prior to March of 1981, except the deaths of Baby  
Woodcock and Baby Velasquez which excited consternation  
on the part of the doctors and which therefore were  
referred to the coroner, but there was no other death  
for which there was not an explanation acceptable  
to the clinicians on the basis of the infants' disease  
state as amplified by the autopsy reports.

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Secondly, in terms of considering  
their reaction to the deaths, it is of central  
importance, in my submission, to bear in mind the  
non-specific nature of the majority of the deaths  
in the context of the evidence that death due  
to digoxin intoxication can mimic death due to  
natural causes in a child with a congenital heart  
defect.

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K-1

DP/ac

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Again Mr. Lamek appears to have recognized this in stating to you at page 160 of his argument, Volume 148, the whole portion at the bottom of page 160:

" My submission, though, is this  
Mr. Commissioner: criticism of the  
hospital or of the physicians  
or of the nurses for not having  
recognized the possibility that  
something may have been seriously  
amiss on the cardiology ward is  
harsh ... "

Then I have read the rest of it.

I can then move on to those two broad areas which I wish to address. The first is, as I told you, how did the doctors respond to the deaths. By way of introduction, it is my submission that the doctors were aware of the increased number of deaths during the epidemic period and responded to those deaths in the manner in which they were accustomed to dealing with other deaths during other periods on cardiology wards.

In summary, the members of the Division of Cardiology reviewed each individual case as it occurred with their colleagues, with their





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2 attention directed to the clinical condition of  
3 the child and the medical management of the case,  
4 with a view to see if the outcome of the case could  
5 or should have been different. In this regard they  
6 were assisted as we have heard by the autopsy  
7 reports prepared by their colleagues in the Division  
8 of Pathology.

9 Just more specifically, how did the  
10 cardiologists go about this process? You heard from  
11 Dr. Rowe about the reviews of deaths ordinarily  
12 carried out at the Hospital and which were carried  
13 out in respect to the deaths in the epidemic period.  
14 They included the Division of Cardiology Work  
15 Conferences, the morning conferences which took  
16 place each and every working day at which a death  
17 would be reviewed, information would be provided  
18 concerning the diagnosis, the infant's condition and  
19 Dr. Freedom would present the gross autopsy report,  
20 and that is one. Secondly, there was a weekly  
21 surgical meeting. Those were attended by cardiologists,  
22 cardiovascular surgeons to discuss surgical deaths  
23 including deaths of patients on the wards post-operative.

24 Thirdly, there were pathology reviews  
25 which were monthly reviews of deaths carried out by  
the pathologists, and fourthly there were the cardiac





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2 pathology reviews. Those were cardiologists,  
3 cardiovascular surgeons, house staff and pathologists  
4 and during the epidemic period two such reviews  
5 were held, one December 29th, 1980 and one October  
6 6th, 1980.

7 I advert specifically to those  
8 reviews to set out the context in which the doctors  
9 approached all deaths and in which they reviewed those  
10 particular deaths. The focus of the reviews was  
11 a clinical one. How could the deaths be explained?  
12 Should surgery have been attempted at all? Should  
13 surgery have been carried out sooner? Should the  
14 child have been transferred to the ICU? Did the  
15 autopsy findings provide any new information to  
16 shed any light on the case? Are the autopsy  
17 findings confirmatory of the clinical diagnosis?  
18 In every instance, a clinical analysis.

19 I am now going to move into the  
20 meetings, and this may be a convenient point --

21 THE COMMISSIONER: Yes, 2:15, then.

22 --- Luncheon Recess.  
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1  
2 ---On resuming.

3 THE COMMISSIONER: I forgot to ask  
4 you, we are not in any trouble, are we, about  
5 finishing this afternoon? Do you anticipate any  
6 problem?

7 MR. ORTVED: No, I do not. I am  
8 approximately one-third into my submission so I  
9 anticipate I would conclude at least in the early  
10 portion of the afternoon.

11 THE COMMISSIONER: That is fine.

12 MR. ORTVED: We are at the stage  
13 now, Mr. Commissioner, where I would like to canvas  
14 the mortality and morbidity conferences, as I  
15 indicated.

16 As of the end of August there had been  
17 12 deaths on Wards 4A and 4B. Two of these had been  
18 reported to the Coroner indicating the level of  
19 concern on the part of the doctors, that is Laura  
20 Woodcock in June and Antonio Velasquez. Autopsies  
21 had been performed on nine of the 12, not having been  
22 performed on Baby Bilodeau whom you will recall  
23 suffered from truncus arteriosus, a lethal form of  
24 heart disease. Murphy, whom you will recall was at  
25 the end stages of gross congestive heart failure,  
and also Heyworth who they also felt was suffering





1  
2 from gross congestive heart failure and whose deaths they felt  
3 were perfectly adequately explained.

4 As of August 1980 we have been told  
5 by Dr. Rowe, Volume 10, page 1751 that the nurses,  
6 through Carol Putherbough communicated to him their  
7 concern regarding the number of deaths and  
8 queried whether this reflected any want of care on  
9 the part of the nurses.

10 When the doctors were made aware of  
11 this concern in light of the number of deaths of  
12 which they were also aware they convened the first  
13 mortality and morbidity conference on December 5th  
14 of 1980.

15 Dr. Rowe selected three deaths for  
16 review, Bilodeau, Turner and Taylor. The minutes of  
17 the meeting are Exhibit 45. A review of those minutes  
18 taken together with nurses Radojewski's notes,  
19 Exhibit No. 46, emphasizes the nature of the review  
20 that was undertaken, namely a clinical one. The  
21 questions asked in analysing each case relate to  
22 how the case might have been managed differently  
23 to achieve better results for the patient.

24 For instance, regarding Baby Bilodeau,  
25 there is querrying as to whether the two dimensional  
investigations done on the evening of admission





1  
2 might have been advanced. In each case Dr. Rowe  
3 pointed out the severely disturbed anatomy and the  
4 high risk of intervention in these cases. The  
5 question of the need for closer monitoring and  
6 ventilatory support for these very ill infants was  
7 raised and I put it to you, as Dr. Rowe indicated,  
8 that it was here that the genesis of the intermediate  
ICU arose.

9 Moving on to that matter you raised  
10 yesterday, namely David Taylor, in his argument at  
11 Volume 148, pages 155 and 156 Mr. Lamek made reference  
12 to Nurse Radojewski's notes in terms of:

13 "...what we recognize as symptoms of  
14 digoxin intoxication..."

15 Regarding David Taylor, and he went on  
16 to specify those symptoms as being irregular heart  
17 rate, ST depression, vomiting, AV block, ventricular  
18 fibrillation and drew your attention specifically to  
19 the notation in Nurse Radojewski's note of the question  
re dig. toxicity. I think, referring to the note, the  
line reads:

20 "ECG: ST depression ? dig. toxic."

21 Mr. Lamek went then went on to suggest,  
22 and this is at page 156 of Volume 148, that the  
23 presence of such a note should in hindsight have put  
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1  
2 the physicians on notice as to the involvement of  
3 digoxin in the death. In my respectful submission  
4 to you, Mr. Commissioner, this is very much hindsight  
5 speaking. Dr. Rowe noted in those minutes that you  
6 have before you that the autopsy showed that the  
7 child's anatomical condition was inoperable. The  
8 staff physicians who have testified before you,  
9 namely Dr. Rowe, Dr. Izukawa and Dr. Rose agreed  
10 that the child's condition adequately explained the  
11 deaths and the references are Dr. Rowe, in Volume  
12 11, pages 1842 to 1871; Dr. Izukawa, Volume 59,  
13 pages 3201 to 3209 and Dr. Rose, Volume 36, pages 7049  
14 to 7054.

15 THE COMMISSIONER: But it was not  
16 any suspicion of deliberate digoxin poisoning, it  
17 was a suspicion of therapeutic overdose, and that is  
18 why I wondered why they might not have followed that  
19 up with a blood test.

20 MR. ORTVED: I am coming to that,  
21 sir.

22 THE COMMISSIONER: All right.

23 MR. ORTVED: Furthermore, you must  
24 consider that notation in the light of the evidence  
25 of Dr. Freedom and the reference is Volume 29, page  
5346 wherein he noted that he had examined the Taylor





1 child on admission and noted at that time that the  
2 child demonstrated an arrhythmia in terms of severe  
3 ST wave depression before, and I emphasize before,  
4 the child was on any cardiac medication.

5               So arising out of that we have the  
6 proposition that such an arrhythmia might be expected  
7 in an infant with the lesion of critically severe  
8 aortic stenosis and this type of symptom also  
9 consistent with digoxin toxicity is adequately  
10 explained by the malformation without any reference  
11 to digoxin. "? dig. toxic" in my submission to you,  
12 Mr. Commissioner, is a perfectly proper and  
13 appropriate designation of a factor to be considered  
14 in the physician's differential diagnosis having  
15 regard to the picture being presented by this child,  
16 that having regard to those specific findings of  
17 Dr. Freedom I put it to you that that suggestion as  
18 part of the differential diagnosis does not stand  
19 as any beacon of any kind especially in a baby of  
20 David Taylor's pathology.

21               Then there is the further evidence  
22 before you in terms of follow-up to that notation  
23 of Dr. Izukawa and that is Volume 59, page 3201 to  
24 3209 and he indicated that following the deaths  
25 he reviewed the child's medication and found nothing  
untoward about the digoxin prescribed.





BB-1

RD/ac

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So in my respectful submission to you without more, and having regard to the pathology observed in this child, the necessity to follow up further perhaps in the manner of post mortem digoxin levels, of course today we would --

THE COMMISSIONER: Today it would be taken automatically.

MR. ORTVED: But then I am just suggesting to you, having regard to the prevailing practice at the time and the particular picture presented by this child is not something for which the doctors sought to be criticized.

THE COMMISSIONER: I went over this and in all probability it is no part of my mandate to criticize them anyway. What I am concerned about, as somebody suggested there was a problem about digoxin toxicity and if that were a problem you would think it would be readily resolved and simple.

MR. ORTVED: I suggest to you it was.

THE COMMISSIONER: It was readily resolved by saying it is not so, but they can't say it is not so, because everybody realizes that the symptoms of digoxin toxicity are the same as the symptoms, or in many cases are the same, as the symptoms from which these children died.





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MR. ORTVED: I don't know if they were that far apart, because I think you are obviously right, or you may well be right, in the sense that perhaps it was not so. Perhaps to have dismissed this was in error at the time. I concede that. All I am putting to you is that having regard to the other factors, which I have suggested were brought to bear on this particular case, the fact that that particular procedure was not pursued is not really all that difficult to understand if you can endeavour to place yourself in the position of those doctors at the time.

THE COMMISSIONER: Well, it is just this, that they take it upon themselves to reassure the nurses, and then with one of the leads they just don't follow up. That is one of just many. You would think that is something that they would follow.

MR. ORTVED: As I have indicated to you, the doctors looked to those things, for which they have evidence, and having regard to the picture presented by David Taylor, the evidence they had resolving it on a balance of probabilities, if you will, suggested to them that this was a result of the baby's lesion and not the result of digoxin





BB3

1  
2 toxicity.

3 THE COMMISSIONER: It could have been.  
4 All the experts say that the symptoms of death  
5 were consistent with digoxin toxicity, so it could  
6 have been. It could have been or it could have  
7 been a contributing factor. That can happen to  
8 a child who is on therapeutic doses of digoxin.  
9 That is why they take the tests all the time. Then  
10 they took the tests. They took tests all the time.  
11 I don't know if they took any tests for the Taylor  
12 baby, but they did take tests regularly with children  
13 on digoxin to make sure that they were not getting  
14 too high.

15 This is one of the things that could  
16 have happened and it just makes you wonder what their  
17 motives really were when they were doing this.

18 It is not an ignoble motive, that  
19 they were just trying to soothe the nurses. If they  
20 were really trying to find out what happened to the  
21 baby, as opposed to just comforting the nurses, they  
22 might have discovered something. That is all.

23 MR. ORTVED: That may be in many  
24 respects a fair comment, because I am prepared to  
25 concede to you that it is apparent from the minutes  
and from the evidence you heard before you that the





BB4

1  
2 doctors were perfectly satisfied as of September  
3 the 5th that this death was a natural death. That  
4 is what brought the nurses together to communicate  
5 to them, so I concede to you this was not an exercise  
6 to run down every last lead, but I am further  
7 putting to you that, having regard to those circumstances  
8 that I have already canvassed, that this particular  
9 aspect of the differential diagnosis is less likely,  
10 at that time, having regard to their picture, than the  
11 anatomy of the child. I can't put it higher than  
12 that.

13 THE COMMISSIONER: Yes, all right.

14 MR. ORTVED: Moving on to September  
15 26th of 1980. That is the occasion of the follow up  
16 meeting in light of the fact that the babies selected  
17 for review at the September 5th meeting were not  
18 totally canvassed. Again, this was a meeting attended  
19 by both cardiologists and nurses in the deaths of  
20 Babies Shrum, Velasquez, and Monteith who were  
21 discussed.

22 The minutes of Dr. Rowe, in relation  
23 to that meeting, have been filed here as Exhibit No. 51.

24 Again, and I can see clearly it  
25 was the doctors' view that those children, save for  
26 Velasquez, had died natural deaths and it was the





BB5

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2 management of the cases that attracted their  
3 concern. So, for instance, if you would look at  
4 those minutes, Mr. Commissioner, and, in particular,  
5 regarding Dion Shrum, you will see that the sorts  
6 of considerations that arose in relation to that  
7 child were, for instance, in relation to the transfer  
8 to ICU, that it had been unsuccessful, the attempt  
9 had been unsuccessful and how to go about accelerating  
10 that in future cases. There is a consideration there  
11 as to whether ventilatory support would have assisted  
12 in this child. These are the kinds of clinical  
13 concerns that were addressed at that meeting.

14 Now, with regard to Baby Velasquez,  
15 you have already heard at great length the view as  
16 to the cause of that death and the fact that it  
17 caused consternation, as a result of which it was  
18 referred to the coroner, but dealing with the meeting  
19 of September 26th, 1980 in its entirety, the suggestions  
20 that arose out of that meeting were again a further  
21 consideration of an intermediate ICU and a large  
22 chart regarding medication dosage to be placed on  
23 crash carts.

24 By the fall of 1980, the doctors,  
25 in my submission to you, felt that they had defined  
the problem relating to the increased number of deaths.





BB6

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2 Overall they perceived the children as being  
3 younger and sicker than those they had previously  
4 been receiving.

5 In their reviews of the individual  
6 deaths, the doctors did not perceive any common  
7 features linking the deaths, apart from the age of  
8 the children and the severity of their illness.

9 THE COMMISSIONER: Yes.

10 MR. ORTVED: So if you look to  
11 Dr. Rowe's note again, Exhibit No. 45, his minutes  
12 of the September 5, 1980 meeting, he makes reference  
13 in the last line to the course of events, the  
14 uniformity, the commonality, the course of events,  
15 and the type of patients that we are now seeing  
16 and I put it to you that that is in the context  
17 of those three patients, Babies Bilodeau, Turner,  
18 and Taylor and Bilodeau was approximately one month  
19 of age, suffering from truncus, a terminal lesion.

20 Baby Turner, 28 days of age,  
21 suffering from severe aortic stenosis and Baby  
22 Taylor, who was approximately three months of age,  
23 who suffered from endocardial fibroelastosis, again  
24 a very severe lesion.

25 I suggest to you that Dr. Rowe  
selected those children for that review, because the





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impression they had at the time that it was  
these younger very, very severely compromised infants  
that they were seeing more and more of in their  
ward.

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THE COMMISSIONER: Yes. We know  
now with hindsight, of course, it was not, not  
the younger children who were dying.

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MR. ORTVED: All right. I appreciate  
that.

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As the CDC has told us, that the  
doctors' impression of the change in population  
was accurate, namely it was younger and sicker, but,  
yes, it was not the younger and sicker ones that were  
all dying. I concede to that, and I will come to  
that.

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It was also the impression of the  
cardiologist at this time that there was a shortage  
of nursing staff on night duty and that might be  
part of the explanation for the ongoing high  
mortality. This impression, combined with the  
severity of illness that they perceive in the  
children lent support to the growing view, among  
the cardiologists, that this idea of an intermediate  
ICU might have a role in assisting to manage these  
patients. It would provide closer monitoring, it





B8

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2 would provide more one on one type nursing than  
3 was heretofore available.

4 Now, I concede Dr. Rowe admitted  
5 in his evidence that it is not to say that  
6 an intermediate ICU, had it been open even as early  
7 as the summer of 1980, would have changed the fact  
8 that the children who died would have died, but what  
9 he was anxious to point out was that it might have  
10 changed the time of their deaths and that it might  
11 have allowed a transfer to ICU and instances, such  
12 as Dion Shrum, where that was not possible, and it  
13 might have allowed certain other measures to be  
14 taken somewhat earlier.

15 Also, in terms of mismanagement,  
16 that question, Dr. Rowe was asked at Volume 12,  
17 pages 2027 to 2020 whether that was canvassed. He  
18 said that the possibility of mismanagement, unintentional,  
19 with respect to the patients was considered, but only  
20 was a very distant possibility. He indicated that  
21 the review of each individual death had not produced  
22 any obvious factor that would suggest mismanagement.

23 THE COMMISSIONER: Are you putting  
24 this to me to say that the doctors acted reasonably  
25 or are you putting it to me to assist with the cause  
of death, because I don't think anyone so far seriously





BB9

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2 has suggested that it was mismanagement in the  
3 sense of not having an ICU or an inadequate nursing  
4 team was responsible for the deaths, that is an  
5 insufficient nursing team.

6 MR. ORTVED: I am putting it to  
7 you in terms of the full picture of the actions taken  
8 on part of the physicians and I already advanced to  
9 you that it is my submission that the response on  
10 their part is of importance to you in assessing  
11 their evidence, as to the cause of death of the  
12 children.

13 THE COMMISSIONER: You see, what  
14 has come out of these two -- I mean the proposal  
15 for an ICU, perhaps consideration of getting more  
16 nurses and doing something about the dosage schedule  
17 of the drugs.

18 The drug business came out of Velasquez  
19 and no one seems to suggest the overdose of narcan  
20 had anything to do with his death unless, of course,  
21 it is an idiosyncratic reaction and presumably the  
22 more you have, you are allergic to a drug, the  
23 more you have the worse the effect will be, I assume.

24 If all you are trying to do is tell  
25 me that the doctors acted reasonably, I thought we  
decided that was not part of my mandate, whether they





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did or didn't.

If you are seriously suggesting that they were right that an intermediate ICU was necessary, that they were right that they needed to have these provisions for the dosage, that they were right they would have to use more nurses, then that may have something to do with the cause of death. I don't think it does, but it might.

MR. ORTVED: I think the bottom line to all of this is to bring home to you the context in which all of these events were being considered by the doctors who had it within their ambit, and that is as a clinical problem.

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I think it might be of some assistance to you in deciding upon the weight to assign to the evidence of these doctors in terms of their opinion of the children's clinical condition, to know the context in which the deaths were analyzed.

THE COMMISSIONER: You see, I think this whole question as to the conduct of the doctors was considered in the Dubin Report, was it not?

MR. ORTVED: It was reviewed extensively.

THE COMMISSIONER: They did make recommendations about the form of the mortality meetings.

MR. ORTVED: Yes, they did.

THE COMMISSIONER: And that sort of thing, and I would be inclined to say that is not my - whether they did it right or whether they didn't do it right

MR. ORTVED: I would agree with you, and I am making submissions, I am not going to be suggesting that it is, and I'm not going to prolong them in the event that you indicate to me, or advise me that this is not going to assist you necessarily in terms of assessing the doctors' evidence as to the clinical condition of the children.

I mean, the bottom line to all of this





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2 evidence is the doctors were addressing the whole issue  
3 in the context of all of the conferences to combat what  
4 was perceived as a clinical problem, with an enhance-  
5 ment as it turned out of the clinic's facilities. It  
6 wasn't, as we know now, probably the right answer, but  
7 it probably wouldn't have hurt, but it may not have  
8 helped, but it wasn't by virtue of any failure of  
anxious consideration on their part.

9 THE COMMISSIONER: I don't believe  
10 there is a doctor in the Hospital for Sick Children  
11 alive that doesn't wish it could have occurred to him  
12 there may have been deliberate digoxin poisoning back  
13 in the fall of 1980, and wishes to God that he had done  
14 something about it, but that is not my concern. They  
15 may be unhappy about it, but I don't know that it  
16 is my concern whether they should have or whether they  
17 did. My concern is whether in fact the children died,  
18 maybe one or two may have died of their clinical  
19 condition, or they died of digoxin poisoning. Digoxin  
20 poisoning did not occur to anybody except perhaps in  
21 the case of Taylor and it occurred in the sense of the  
22 therapeutic dose and apparently occurred, then it was  
23 dismissed because it wasn't followed up. What will I  
24 get from that? The only thing that I could draw from  
25 that is that it is unfortunate that the doctors didn't





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make that inquiry, that has already been said in the  
Dubin Report and I don't want to repeat it.

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MR. ORTVED: I have addressed the  
rationale for that and I can't help you further.

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THE COMMISSIONER: Does it help me in  
determining because they could have been right, and  
they may well have been right in their determination  
of what caused these children to die, does that really  
help me? Because they were not considering it, that is the  
only alternative.

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MR. ORTVED: Well I don't know that  
that is a fair comment because it seems to me that you  
have to consider very materially the evidence of the  
clinicians as to the clinical condition, along with  
the evidence of the other experts you have heard who  
did consider that digoxin aspect.

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THE COMMISSIONER: Yes. All right.

MR. ORTVED: And that is what this is  
directed to.

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THE COMMISSIONER: Okay. You say  
because they gave it extra consideration, they looked  
carefully at the state of these six children and  
reached the conclusion that they died of their  
clinical symptoms, that is - that they might have made  
a special effort.





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2 MR. ORTVED: I think I can take it  
3 further and say going right through to January of 1981  
4 in terms of the review that was carried out of the 20  
5 babies at that time. As Mr. Lamek has indicated to  
6 you, the actual morbidity and mortality conference  
7 that they had on that date didn't address the issue  
8 of how those babies died. In terms of preparing for  
9 that Drs. Rowe and Jedeikin did. That again I submit  
10 to you is something that has to be considered by you  
11 in your determination as to how the babies, included  
12 in that review up to January 12th, 1981, died, and it  
13 shows the extra measure of consideration that was  
brought to each and every one of those children.

14 You see, we spoke earlier about  
15 evidence that the doctors had to assist them in how  
16 the deaths could be accounted for by the children's  
17 clinical condition; how the symptoms of digoxin are  
18 non-specific and how their views were supported by the  
autopsy reports.

19 Now again I think that those sorts of  
20 considerations must also be borne in mind by you in  
21 terms of assessing the respective doctors' opinions  
22 concerning the deaths of those children in addition  
23 to the opinion of the expert who happened to consider  
24 the digoxin phenomena.  
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2 THE COMMISSIONER: I suppose the  
3 answer that can be given, and I think has already  
4 been given, is that they didn't consider it.

5 MR. ORTVED: It is just that when they  
6 came before you Mr. Lamek asked them to do exactly  
7 that.

8 THE COMMISSIONER: Yes, they did it  
9 now.

10 MR. ORTVED: But they didn't do it  
11 then.

12 THE COMMISSIONER: But they didn't do  
13 it then.

14 MR. ORTVED: And they have, each and  
15 every one of those children has been the subject  
16 matter of opinion evidence on the part of those  
17 cardiologists before you as to the cause of death.

18 THE COMMISSIONER: I accept all of  
19 that, but I say is it not natural for somebody who  
20 reached a conclusion of fact and professionals have  
21 reached a conclusion to try to understand it, isn't  
22 that the reasonable thing to do, isn't that a reason-  
23 able proposition? If some judges and commissioners  
24 who reach conclusions want to change them, it is a  
25 natural animal response.

MR. ORTVED: I understand that, but I





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think it also has to be weighed in the context of the individual before you.

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THE COMMISSIONER: Oh yes.

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MR. ORTVED: And I think, for instance, Dr. Rowe whose submission to you was very fair.

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THE COMMISSIONER: I am not suggesting anything else, he is a great cardiologist. I am just saying it is human nature.

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MR. ORTVED: I think that he very fairly said there were certain cases where the possibility of digoxin intoxication had to be seriously considered. That seems to me to be other than simply defending one's view, but it isn't as though those doctors appeared before you with their minds closed, without having envisaged the digoxin intoxication.

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THE COMMISSIONER: No, their minds were not closed, they were looking at it. I don't know, perhaps they are better men than I am. I know once I have made up my mind on something - I'm not trying to defend them, maybe I should be a little more open, but I have a touch of honesty and I think that once the doctors, the people who are involved in it have reached a conclusion as to the death of a certain child, there is pretty strong evidence, the evidence





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2 of let's say the reading for Estrella which is now  
3 in doubt, that sort of evidence obviously moved the  
4 doctors from what they thought before. But no strong  
5 evidence came out for any of the others. Generally  
6 speaking, the strong evidence didn't come out to make  
7 them change their minds. Maybe in the case of  
8 Lombardo, Belanger and Hines. Let's take Woodcock  
9 and Velasquez, take any of these, they finally reach  
10 a conclusion and there is no strong evidence that they  
11 are wrong. There is no strong evidence of whether it  
12 was digoxin or something else, did you really expect  
the doctors to change their mind?

13 MR. ORTVÉD: I must say my impression  
14 of them was if this other factor was added to their  
15 differential diagnosis albeit at a much later time --

16 THE COMMISSIONER: The only other  
17 factor is that perhaps other babies were poisoned,  
that's all.

18 MR. ORTVÉD: Even taking that as a  
19 given -- yes, I think they would be prepared, and that's what  
20 Dr. Rowe indicated that he was prepared to do --

21 THE COMMISSIONER: He didn't, he  
22 changed his mind only at the last, he changed his  
23 mind only on the ones with strong toxicological  
24 evidence, he didn't change his mind on any of the ones  
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where there was no toxicological evidence.

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MR. ORTVED: Precisely, and that really makes --

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THE COMMISSIONER: And Mr. Scott has been supporting me on that throughout the day.

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MR. ORTVED: And that is what I have been advancing here, namely that doctors looked for evidence, objective evidence, and that was the type of objective evidence that was sufficient to at least allow Dr. Rowe to consider an alternative.

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You see, the bulk of my submissions has to do with this whole aspect of the consideration that was brought to bear by the doctors on the babies in question throughout this period, with a view to assist you, to assist the weight of their opinion as to the cause of death. Because it is my submission to you that is of considerable weight and could be of assistance to you.

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If, in fact, the reasonableness of the actions is not a matter before you and you are saying that you are really not much assisted by arguments to support that opinion, then I can probably --

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THE COMMISSIONER: I am certainly interested in any argument to support the position, but I thought you were putting to me the proposition





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2 that because they studied it long and hard at the time,  
3 therefore I should accept their opinion now?

4 MR. ORTVED: No.

5 THE COMMISSIONER: I am just putting  
6 it to you that they didn't consider one other feature,  
7 they didn't consider that at the time, and then I  
8 propose to you and maybe I am wrong, I thought that  
9 people, once they made up their minds they were hard  
10 to move from that proposition. That is what in the  
11 long distant days I used to tell juries anyway they  
12 should keep an open mind until all the evidence was  
13 in. These doctors thought all the evidence was in and  
14 they reached a conclusion. Then there is the  
15 possibility that there was some other evidence but  
16 having reached the conclusion they did it is very  
17 hard for them to go back on it.

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MR. ORTVED: In my respectful submission that was not necessarily borne out by the evidence of the doctors before you, and I have used Dr. Rowe as an example.

THE COMMISSIONER: I could not see where one doctor from the Hospital for Sick Children had reversed himself on any child for whom there was no toxicological evidence.

MR. ORTVED: I think that is probably a fair representation of their feeling.

THE COMMISSIONER: And they may be right. It seems like another one of those coincidences that we have to face, that there was not one that ever, no matter what happened, through this rash of deaths in March, many of those with strong evidence of digoxin poisoning.

MR. ORTVED: I think it comes back to the point that Mr. Scott raised for you and that is the doctors obviously, the doctors from the Hospital for Sick Children, obviously started from the proposition that these deaths are natural until they can be proved otherwise to their satisfaction. It may not be the approach which you choose to take but it is certainly the approach which Mr. Scott and I urge upon you as the appropriate one.





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THE COMMISSIONER: It may be the appropriate one for the doctors but is it the appropriate one for me?

MR. ORTVED: In my submission, yes.

THE COMMISSIONER: It was not obviously the approach that the police or the Crown Attorney took.

MR. ORTVED: No, they are paid to be suspicious. That is why we pay police officers and that is why we pay Crown Attorneys but that is not why we pay Commissioners.

THE COMMISSIONER: I will not involve you as a character witness in the next phase.

MR. ORTVED: I venture to say that the best police officers are the ones with the highest index of suspicions but that surely is not what Commissioners are supposed to do. Commissioners, and I don't want to repeat all of Mr. Scott's argument, are supposed to assist us with reports based on the substantive evidence and in my submission that comes back to where the doctors are.

THE COMMISSIONER: All right, thank you.

MR. ORTVED: Let me go on to Janice Estrella and talk about that child. Clinically it





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2 was the impression of the physicians that here was  
3 an extremely ill child with considerable congenital  
4 heart and other defects. She was felt to be a  
5 difficult management case and there were problems  
6 with stabilizing her digoxin levels ante mortem.  
7 The difficulties in the case centred on why a post  
8 mortem digoxin level was ordered and how to interpret  
9 the results. Two post mortem levels were obtained  
and samples taken after the autopsy.

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10 With respect to that first matter,  
11 Mr. Lamek in his argument at Volume 148, page 166  
12 has argued that the evidence of Dr. Taylor is to be  
13 preferred over Dr. Freedom and that you should find  
14 that Dr. Freedom ordered that a blood sample be  
15 drawn on autopsy for digoxin assay. In fairness,  
16 Dr. Freedom's evidence is found at Volume 29,  
17 page 5440 and it was simply to the effect that he  
18 had no recollection of that phone call. He went on  
19 to say at page 5449 that he believes there was a  
call from Dr. Taylor but he simply has no recollection  
of it.

20 In my submission to you there really  
21 is not a conflict on the evidence. We are aware  
22 that Dr. Taylor drew two samples of blood after he  
23 completed the autopsy on Estrella from the pelvic  
24  
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2 cavity and from the leg vein by way of milking it.

3 Some time after the result of the  
4 sample was obtained by Dr. Taylor he had an informal  
5 discussion about the one level of 72 nanograms per  
6 millilitre. Both doctors viewed that result as an  
7 error or as an artefact. Dr. Freedom told Dr. Taylor  
8 to check it out but Dr. Freedom and Dr. Taylor both  
9 did nothing further at the time. The matter was  
10 raised again by Dr. Taylor to Dr. Mancer at the  
11 beginning of March at the time Dr. Taylor was reviewing  
12 the matter with him in preparation of the final  
13 autopsy report.

14 The report was revised to include  
15 a reference to the contaminated sample.

16 During the course of questions both  
17 Dr. Taylor and Dr. Freedom much was made of the  
18 failure to do anything more to check out the levels.  
19 There are two responses really. In the first place  
20 whether the doctors did or did not check out matters  
21 further in January is not a topic that will really  
22 assist you in determining how the baby died.

23 THE COMMISSIONER: Just looking here,  
24 this has been done in the Dubin Report too.

25 MR. ORTVED: Dubin Report too. It was  
something that was raised by Mr. Lamek in his argument





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and I feel compelled to respond to it.

THE COMMISSIONER: Page 158 of the  
Dubin Report it says:

"We think that something further  
should have been done before the result  
of that test was rejected out of hand."

It is hard to quarrel with that in  
hindsight, it should have been, but that is not my  
problem. My problem is whether the readings were  
right or wrong.

MR. ORTVED: As Mr. Lamek's pointed  
out even had the matter been followed up then the  
results would have demonstrated the suspect source and  
it would have ended that. But because it was raised  
by him in his argument I felt compelled to deal with  
it.

THE COMMISSIONER: I am not prepared  
to accept that. It might have ended there. There  
might have been some tightening of rules, it might  
have had that effect. They might have said we don't  
know whether this is a true or false reading but in  
future we are going to watch, because there are two  
ways, deliberate or accidental dose, and we don't  
want it to happen again. That is what the Dubin Report  
is saying.





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2 MR. ORTVED: I think it is again in  
3 the context of looking back on all these events  
4 subsequent to March of 1981 and of course that is  
5 exactly what is being done to this day and I have  
6 no quarrel with that. The only issue I take is  
7 whether or not the actions on the part of the doctors  
8 in the circumstances were understandable, having  
9 regard to what they knew at the time. Even had they  
10 done something, what would happen? I can refer you  
11 to Dr. deSa as well. He made reference to this in  
12 his report, that is Exhibit 283, and he indicated he  
13 was not surprised at the reaction of the Department  
14 of Pathology, page 22 of Exhibit 283, he states:

15 "I am firmly convinced that the vast  
16 majority of trained pathologists with  
17 expertise in autopsy pathology would  
18 have regarded the Estrella infant's  
19 digoxin levels at autopsy as being  
20 due to a laboratory error. The actual  
21 figures quoted (7.8 ng./ml. pre-mortem  
22 and 72 ng./ml. post-mortem) differ  
23 by a factor x10, making the possibility  
24 of a multiplication error in the  
25 laboratory calculations of the level,  
a perfectly plausible explanation."





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Apart from the level --

THE COMMISSIONER: You could ask if they made a mathematical error but they did not bother with that.

MR. ORTVED: Yes, the evidence was that they did discuss that.

THE COMMISSIONER: They never asked the biochemist if he had made a mathematical error?

MR. ORTVED: They did not go back to the biochemist. That was what Dr. Mancer and Dr. Taylor considered when they got together and they could not run it to ground.

THE COMMISSIONER: I don't think I would have had much trouble running it to the ground. I would have asked, did you make a decimal point error and have it checked again just the same as Mr. Cimbura in the pelvic cavity study, he checked and checked and double checked and multiple checked when he got that figure of 179. He said it doesn't make sense, it is not right but he kept on doing it and found it was correct. They could have done something like that. They did not do that.

MR. ORTVED: In fairness they did check it. They did re-calculate it, Mr. Mancer and Dr. Taylor did and they found out the value of 72 was





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2 correct and at which point in time they decided that  
3 it must be an artefact, that it must have to do with  
4 the contaminated sample. That was the evidence.

5 Apart from that level there were not  
6 outside factors that would cause the physicians to  
7 turn their minds to an explanation of the incident,  
8 in my submission, because as Mr. Lamek has averted in  
9 his submission to you the doctors had just completed  
10 their mortality and morbidity conference on January  
11 12, 1981. That was the day after the Estrella death.  
12 That meeting as I think Mr. Lamek has very accurately  
13 indicated really served to reinforce the doctors'  
14 impressions that probably there should be more close  
15 monitoring of the "younger and sicker" infants  
16 particularly during the night time hours in order  
17 to maximize their chances of prolonged life. Janice  
18 Estrella really was another one of those babies, very  
19 young and very sick, and her death, although not  
20 included in the review in my submission really was  
21 confirmatory of this result.

22 Can I move to the whole issue of  
23 patterns. Maybe I should do that after the break,  
24 Mr. Commissioner.

25 THE COMMISSIONER: Fine. 20 minutes.

---Short recess.





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--- Upon Resuming.

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THE COMMISSIONER: Mr. Ortved.

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MR. ORTVED: What I have done on the break is review the balance of my submissions concerning patterns and I think that in fairness I would have to concede that those submissions are directed to the same issue that my submissions followed at the luncheon recess, namely an understanding of the doctors' position which, as you have indicated, may go to the reasonableness of their actions but may not be directly relevant to the whole issue of cause of death.

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Now, with that in mind, I think that I meet the same objection, in advancing those submissions to you that you raised with me in relation to what evidence did the doctors have other than natural causes.

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I am not positive that you would be necessarily assisted by them in terms of what you conceded to me is the main focus of your inquiry, mainly cause of death.

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I think with that in mind what I would purpose to do is reserve those submissions until it is necessary, perhaps in reply, to get into them in the event I feel it is necessary to





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respond to any of the Counsel who raises them as  
a consideration and you hear those submissions.  
I don't feel that they flow out of any submissions  
advanced to you by Mr. Lamek, as I did with certain  
other submissions before lunch.

THE COMMISSIONER: Certainly he  
is talking about patterns and patterns part of the  
circumstantial evidence I guess one could infer.

MR. ORTVED: That's right and Mr. Scott  
has dealt with that aspect of it.

THE COMMISSIONER: Yes.

MR. ORTVED: In terms of those  
patterns to which Mr. Lamek made reference --

THE COMMISSIONER: Yes.

MR. ORTVED: -- being really neutral  
in terms of indicating digoxin or natural causes,  
as a cause of death, so I don't intend to get into  
that. That wasn't my intention to argue that.

THE COMMISSIONER: The only things  
was the doctors should not have been affected by  
the pattern if there was a pattern. This is what  
you were going to tell me, they should or should not  
have been affected in their views.

MR. ORTVED: Precisely.

THE COMMISSIONER: -- Their views at





EE3

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2 that time and whether they were correct in reaching  
3 their views at that time doesn't really concern me.  
4 It is not part of what I have to do, whether they  
5 should have been doing some more investigation. I  
6 am instructed in the next phase to consider the  
7 conduct of the police, but I don't think that  
8 investigation includes the doctors. Nobody so far  
9 has suggested it includes an examination of doctors'  
10 investigation.

11 MR. ORTVÉD: I am not before you  
12 suggesting that.

13 THE COMMISSIONER: Good. I am happy  
14 to hear you say that. I actually was able to gather  
15 that from certain of your responses to me before  
16 the recess.

17 The worst that would happen to your  
18 clients, in my report, would be to say that this  
19 matter has been dealt with the Dubin Report and I  
20 have nothing to add. Would that offend you? Do  
21 you really object to anything that was said in the  
22 Dubin Report? It would have been nice, would it  
23 not, if they had followed up on the Estrella reading.

24 MR. ORTVÉD: I am certainly content  
25 to live with the Dubin Report.

THE COMMISSIONER: That was their





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mandate and it is not mine, at least as I understand it.

Now, if somebody later on persuades me that it is then you can come back and deal with it then, but I don't think you have to deal with it now.

MR. ORTVED: That is what I purpose to do. This may create a difficult situation, insofar as Mr. Young is concerned, but having regard to the position you advanced now then I will sit down.

THE COMMISSIONER: If it becomes, subsequently, that the doctors do it may well be relevant in Phase II and then we can deal with that.

MR. ORTVED: That concludes my submission then, Mr. Commissioner.

THE COMMISSIONER: All right. I guess we have no further business then.

Now, Monday it is 9:30 and Mr. Sopinka will be on deck and following him I think Mr. Sopinka told me that he would be short and he would have written argument. Have you any thoughts on how long you will be?

MR. STRATHY: I think you can count on me for the day on Monday.





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THE COMMISSIONER: For all day?

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MR. STRATHY: All day. There is  
a chance I might go on, but I hope to finish  
Monday.

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THE COMMISSIONER: Yes.

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MS. CECCHETTO: Approximately  
two hours Tuesday morning.

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THE COMMISSIONER: This will be  
by Tuesday?

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MR. YOUNG: Yes.

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THE COMMISSIONER: Would you take  
less than a day?

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MR. YOUNG: No, sir. I would think  
there may be some time at the end of day that we  
are finished.

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THE COMMISSIONER: I think Miss  
Kitley gave some indication of half a day.

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MR. OLAH : I believe so. Yes.

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THE COMMISSIONER: Well, I don't  
know how long. Mr. Olah, I guess you are after  
that.

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MR. OLAH: I would not expect to  
be more than an hour, something in that order.

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THE COMMISSIONER: That leaves the  
parents and then of course we have to come back up

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the line. I confidentially expect coming back up  
the line will be a relatively short enterprise  
unless somebody is raising something very serious.

All right. I think we all hope of  
getting through next week, but we have a good hope  
of finishing reasonably early in the week following.  
It gives lots of time for people who want to fool  
around in the Divisional Court.

--- Whereupon the hearing was adjourned until  
Monday, June 18th, 1984 at 9:30 a.m.

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